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POST-ENCEPHALITIC BEHAVIOR AND THE GENERAL PRACTITIONER*

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Post-encephalitic behavior disorders begin in the domain of the psychiatrist but soon spread over into the territory of the general practitioner, which is as it should be.

The central part of the problem is an affair for the specialist. Epidemic encephalitis is an infection of the brain substance. In severe cases it brings death, epilepsy or Parkinsonian symptoms. In mild cases it brings about curious changes in the character of children. So that here there is an infection which brings bad behavior, even some kinds of crime, into the medical field.

The stories of many children, who, after an evident or concealed infection of the brain began to behave in anti-social ways, showed that there were loose in the world intelligent, overactive children going from bad to worse, for whom there was no provision in existing institutions. In December, 1924, the Pennsylvania Hospital established a school for these children which has continued to the present day, and in this school there has been the continued consideration of some of the medical factors which may enter into the problem of juvenile delinquency.

Trained teachers and trained nurses were placed in charge of a group of 20 children in quarters separate from the buildings in which adult mental patients were housed. A "long distance" plan was followed which called for no responses on the part of the personnel in charge which were not considered a long time in advance. All those in control had the same unified plan of procedure and it was soon found that no substitute could be brought in without interfering with the children's progress. This was in great contrast to the state which had prevailed in the children's homes because there the behavior had been of just the sort which brought forward impatience and anger on the part of adults . . . behavior which led the adults to do anything for the sake of immediate peace and quiet.

The results of this work have to be stated in two parts. Of 60 or more children there was improvement in the school of all but two. A good proportion of those children who went home did extremely well; apparently the current of their illness had been changed from a bad to a good direction. This latter result was also in the face of home conditions which often were bad and without the social service supervision and preparation.

It appeared from this experiment that secondary and very wide-spread changes in these children continued while the progress of the brain lesion stopped. The organic process was, then, only a mild disarrangement which could be duplicated by other agents, such as have been described in the Journal of the American Medical Association during the last few years. In articles in the Journal the following agents are listed: mumps, measles, vaccinations, intracranial birth injuries, arsenical therapy, malnutrition, and such blows on the head as are received by pugilists or in automobile accidents. All of these agents may sometimes reach out and touch the brain lightly enough to cause damage and yet not to be easily recognized. And as there is some ground to think that encephalitis as an epidemic may be on the wane, it is disappointing to think that injuries by automobile in milder grades are increasing to provide an adequate substitute.

It is evidently not the Neurologist or Psychiatrist who will see the majority of the milder cases, but the doctor in general practice. If the family physician can recognize the situation early and take charge of the unstable emotional situation at once he can stop much of the trouble at its source. It is well to be over-suspicious as the remedy can do no harm. That family is fortunate which has a physician who in any serious illness of the child will prepare for a dangerous

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emotional convalescence. Here is a delicate child, used to the limelight, perhaps tremendously scared by some feature of his illness and surrounded by anxious and over-tired parents. The doctor should not step out when the fever goes down but should remain to advise the parents about re-establishing every good habit which the child ever had and about building new habits . . . in short to establish the long distance plan of education.

There is a cheerful side to the picture. Experience with many children who have suffered not only from true epidemic encephalitis but also from pseudo-encephalitis, shows that the resulting behavior trouble is not due to the brain lesion only but the lesion plus ignorant and inefficient handling of its results. If the child is allowed to feel insecure, if he is misunderstood, laughed at, spoiled, a bad outlook is sure. Treatment then, can logically be aimed, not at the unreachable organic process but at the emotional re-education, character making, and ought to be about the same as can be applied to all unusually bright and active children who get into trouble at home and at school. "After all," as one of our physicians said, "these post-encephalitic children are like all children, only more so." Every doctor can do much to relieve the tremendous feelings of inferiority and insecurity that hamper childhood.

It would be a wonderful thing if almost all of "the bad behavior cases"—modern tragedies —could be turned back at their source by general practitioners who knew how to handle the mental factors in feeding, illness and convalescence, leaving only a few of the most clearly defined to go on to a specialist's care—preferably for training in a cottage under the supervision of a state hospital for mental diseases.

DISCUSSION

DR. M. A. TARUMIANZ (Farnhurst): I am sure I enjoyed the paper very much. I am sorry that Dr. Bond had to abstract his paper, knowing Dr. Bond's ability to present his subject from meetings of the American Psychiatric Association, of which he was president and secretary for many years. We all know Dr. Bond is one who goes deeply into any subject which he presents to a group of professional men.

This behavior problem is as acute in our state as it is in Pennsylvania. Dr. Bond was one of the first men to establish a school for post-encephalitic cases and behavior cases. Since then New York, and also Allentown, Pennsylvania, have established such institutions.

A few years ago I presented a paper before this society, at which time I recommended that such an institution or such a department should be established in this state to take care of those unfortunate children who had an attack of encephalitis and were suffering from post-encephalitic conditions, at which time I am proud to say this Society approved such a move, but, unfortunately, we have not been able to establish such a department in our state institution because of lack of funds.

It is, it seems to me, very unfortunate that these children here, obviously suffering from behavior problems, have to be put with adults in state hospitals. Undoubtedly their environment is not fit for any sick children. In addition to that, their connection with adult insane individuals undoubtedly is not very good for them, nor for the adult insane individuals, or mentally ill individuals.

We have found there is very little improvement in the condition of those who are in the state hospitals without having special departments for those cases; therefore, I should like to ask Dr. Bond just one single question: whether he approves such a department—I know he mentioned that it is a proper thing to establish it, but whether he approves and recommends having such a department for a small state such as ours. We usually have about twelve to fifteen children at our place. That is the average number of children that we take care of.

In addition to this, I am sure Dr. Bond will agree with me that among thirty or forty thousand children, which is the number we have in the State of Delaware, there are undoubtedly a few hundred children who need proper care for this behavior problem.

Since we have had a mental hygiene clinic, we have come in contact with the severe problem cases.

Thank you!

DR. BOND: To answer one question, there seems no doubt that in every state of the Union there should be a cottage on the grounds of some state hospital to take care of children. Anyone

who has seen one or two or more children on wards for adults, will never wish to see that situation again. It is just as bad for the adult as for the child, and for the children as for the adults. If such a cottage should be built in Delaware, it would undoubtedly be of increasing usefulness to the state.

MODERN PSYCHIATRY*

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Psychiatry, at the present time, is progressing rapidly, and the importance of special training of the psychiatrist is equalling that which is considered necessary in the other specialties, such as ear, nose and throat, surgery, etc. Up to the present time the medical schools have rather neglected this specialty in their curriculums as only a very few lectures on mental disorder were given to the students during their four years of studying. Moreover, the medical students were confused by the fact that they were forced to study the abnormal mind without having adequate training in the normal, since psychology, the study of the normal mind, has not been a prerequisite for medical training, and without this knowledge of the functioning of the normal mind, the study of psychiatry was extremely difficult and at times confusing to the student. He was forced to listen to lectures often somewhat beyond his understanding and he naturally lost interest and waited patiently or impatiently for the course to end. The required readings in the subject were inadequate and the professors of psychiatry themselves often felt the difficulty of the problem that confronted them in teaching a subject for which their students were inadequately prepared. Because it was impossible to interest the average student in this specialty, there have always been fewer psychiatrists than were needed to properly care for the mentally ill. Training consisted in experience in the state institutions where a few of the younger medical men entered as junior physicians. Usually this was merely a method of earning a certain amount of money during the first few years out of medical school to enable them to go into some other types of work when sufficient funds were saved to warrant such action. A great number of them would leave the hospital after a year or two—when they were just beginning to understand the principles involved in the abnormal mind. Unfortunately, only the superintendents were well versed in the problems and the average physician working in the state hospital was not considered to have as high a standing as those men in other fields. This opinion was enhanced by the fact that up until recently the institutions for the insane were rather negligent about the physical care of the patient and the work consisted of routine procedures, with the use of mechanical and drug restraints. Stereotyped remedies were given for acute physical conditions, and the only surgical procedures were those of emergency type. At this time they were custodial institutions, and were not equipped for the young doctor just out of medical school.

This, however, has radically changed in the last decade or two, until now psychiatry is considered to be of the same importance as any other branch of medicine. With the increased interest in the problems and as the leaders in the field saw the necessity of intensified training for psychiatrists, fellowships were offered in this specialty by various funds. Some of the institutions to which fellowships were granted were the Boston Psychopathic Hospital, the Henry Phipps Psychiatric Clinic, and the Colorado Psychopathic Hospital. Other fellowships were granted to out-patient clinics, and did not stress active psychiatry to so great an extent, but dealt more with preventive work. Some of them required previous training in psychiatry in an institution for the insane. The Colorado Psychopathic Hospital trained men who had not had previous experience, and instituted a two years' course in psychiatry, and allied subjects. In this institution the fellows are required to make a complete survey of the literature in this particular field. They are also given direct clinical contact, both in the institution and in the out-patient department. Some participation is taken in the research work in this particular hospital. The course is very adequate and includes study of the abnormal mind, both of the adult and the child. Unfortunately, it has not laid much stress on crime, which is a field that is being rapidly taken over by the psychiatrist. It has stressed,

* Read before the Kent County Medical Society, Smyrna, Delaware, December 2, 1931.

however, the importance of the complete knowledge of the normal mind before a full understanding of the abnormal could be reached.

The psychiatrist's work has increased to a great extent. Formerly, he cared only for the decidedly insane person who was not able to remain in the community, but had to be incarcerated to protect society in general. These cases were often of a hopeless type, either completely deteriorated or violently insane. The psychiatrist was given the patient in the last stages of the disease, and naturally no better results could be expected than from the surgeon to whom a case of cancer is brought in the last stages where operation is impossible. Like the surgeon, he was able to alleviate the symptoms to some extent, but he was not able to cure the condition.

As Kraepelin became more interested in mental disease and classified various types that existed, interest was aroused among a few men who have since educated not only the professional people but the laymen as well—so that the understanding of the abnormal mind became clear and patients were brought into the institutions in earlier stages of the disease, and the percentage of cures naturally grew larger. As the cases began coming in—in the earlier stages, voluntary commitments occurred, and patients with insight into their own conditions were carefully studied. This led to broadening of the field until finally abnormal behavior in children gradually was taken over by the psychiatrist. It was felt that the normal person always lives within the social code and that the person who becomes asocial in any way must be abnormal to a certain extent. Criminals were studied by the psychiatrist for signs of abnormal mental trends, so we now see that the specialty not only undertakes the care of the actually insane but the care of all deviations from the normal, no matter how slight. As the difference between organic and functional conditions was clearly outlined, the psychiatrist was necessarily forced to become a neurologist so that he would be able to care for the organic as a definite pathological brain process.

It has been extremely unfortunate that the training in the medical schools has been so slight that not only the average practitioner but also the specialist outside of the field of psychiatry has not thoroughly understood the conditions as they exist. The state hospital to some is still a place where people go for the rest of their lives and for whom nothing can be done. The research work which has been done in this field has been published only in the psychiatric periodicals and does not reach the desks of all doctors. Many do not know that one of the latest results is that the abnormal mind can be stimulated to become normal by the administration of carbon-dioxide. This indeed is only a temporary phase, but it has opened the field for much further research. If the mute resistant catatonic patient can be brought to normal for a half hour there is reason to hope that means will be found whereby such a patient's contact with reality can be prolonged.

Although the malaria treatment for general paresis is becoming better known, yet there are very few who realize that patients who were to all appearances completely deteriorated and chronically insane—have been, to all outward appearances, cured for a period of six to seven years. Whether this is a permanent cure or not cannot be decided at the present time, as the period between the discovery of this treatment and the present day has not been long enough to make any definite statement. As this method of treatment became known, some practitioners have felt that these organic conditions were not fit subjects for the state hospital—but treatment should be carried on in other places. This fact, of course, would be erroneous to any physician who had seen a patient suffering from cerebral syphilis in any form, as it is obvious that such a patient could not be cared for in a general hospital without a psychopathic ward, nor could he be allowed to remain at home without possibly doing a great deal of damage.

When it is realized that the percentage of cures of mental diseases ranks well with that of the cures in general hospitals, and when these figures have been brought to the attention of the physicians, then only can we hope that there will be a realization that the work which psychiatrists do is not of a hopeless type.

Unfortunately, during the last twenty years psychiatry has received another blow, due to the work of Freud. I do not wish to take issue with Freud's teaching, but rather with the popular interpretation which was given to it. Freud, with his analysis of the mind, has done a great

deal for this specialty, as it has led to a new technique in the care and treatment of the patient. He produced a philosophy which the average man could only grasp with a certain degree of disgust, since he was unable to thoroughly appreciate the underlying principles. He failed to emphasize that there possibly could be other conflicts in life which were not based on the love-life of the individual. As his material was written so that it was more or less popular, it immediately came to the fore in the public's mind and was a subject for much discussion. Since true psychiatry was beyond the understanding of the average natuure, and since Freud's work was within the understanding of the average individual, it was natural that he should arouse interest. It was also felt that all psychiatrists followed his teaching and were thoroughly in favor with his work in the limited conception of the general public. Very few people realized that his teachings are broader than the public conception claims it to be, and that no psychiatrist considers psycho-analysis as a cure for all mental disorders. It is now necessary to place psycho-analysis in a proper nook and to realize that although a part of psychiatry it certainly does not cover all conditions which come to the hands of the psychiatrist.

Let us now consider the evolution of the psychoses. The Declaration of Independence states that all men are created equal. Contrary to fact, the physical and mental makeups of the individual are not equal. Some have inherited psychotic trends; others have inherited deficiency. Moreover, we are not all treated equally as children, and there are built up various impulses, fears and definite compulsions. Life in the early years of the individual plays an important part as the child reaches adult life and must mix with the social order of things. It is true psychosis in childhood is indeed very rare, if we eliminate encephalitic conditions; but, the bases for psychoses are laid very early in life. Moreover, there is a close linking up of the mind and body and as during the critical period of adolescence the glandular system, of which we know so little, reaches its final development, there may be caused such a serious mental turmoil that insanity finally develops. Although before adolescence abnormal trends can be recognized, it is only during and after this stage that definitely personality reaction types and also habit formations become firmly fixed and we have a serious problem in changing the mental grooves which are then existent and which become more fixed, as the complexities of life increase and taboos become more numerous. Then, there is bound to be a conflict between the individual's desires and the modus of living as set up by society at large. Unless the early training of the individual has been such that he can understand the reasons for things, so that he can control his own desires, functional difficulty will arise. Although sex life, selfpreservation and such factors play an important part in the makeup of the individual, it is the establishment of the personality or the will to power which plays the predominating role. The ego, that indefinable something, which is the individual and is composed of all the ideals and philosophies of that person, continuously strives to be on top. Every child and every adult desires to excel in some field to establish his personality. His ability to excel depends upon the inherent qualities in his mental and physical makeup and if the ego has been able to establish itself with peace with the social law, insanity does not develop. But, when something happens in the environment of the individual which strikes viciously at the ideas built around the ego, abnormality develops and may go on into insanity. The type of psychosis may easily be conceived, depending upon the type of personality which has been shattered by the difficulty. For instance, an extroverted type of person, when in conflict with his environment, develops a manic depressive psychosis, while an introverted type develops dementia praecox.

Now, we say the development of the ego depends upon the inherent mental and physical makeup of the individual. It can easily be conceived that the glands of internal secretion may play a very important part in the fundamental personality type. We can all realize that hyperthyroidism goes with extroversion, that is, talkativeness, sociability, excitability, etc., but we know, in spite of all the work that has been done, very little about the other glands. However, we do know that they play an important part in the bodily development and they may as well play an equally important part in the mental development of the individual. Whether the glandular development is the actual underlying

cause of the psychosis through its development of the ego and the environmental difficulty merely the precipitating factor can readily be visualized.

Up to this time, our discussion has mainly involved the functional psychoses. The organic psychoses may be described as those which are known to be due to some physical cause. They are equally as important but are rapidly yielding to treatment and prevention. Let us consider the most important of these organic psychoses, general paresis, which is marked by severe disintegration of the personality—classically pictured as being associated with delusions of grandeur, with crumbling of the business and ethical senses. This psychosis, like all others, does not develop immediately or suddenly. Previous to the final break, it can be noticed that the individual is not carrying on his business as well as formerly, although his actual contact with reality still remains intact. This may be considered as a pre-paretic state, and at this time it may be treated very successfully. We then have the toxic psychosis with its periods of confusion, disorientation, with symptoms more like a delirious condition. These cases need physical care and physical care only. Occasionally, they react well to simple dietary measures.

We also have various psychoses occurring with epilepsy, different nervous diseases, pernicious anemia, and other physical conditions, many of which are temporary in type and improve with the improvement in the physical condition.

Let us now consider a disease which we know the least about, viz., dementia praecox, a condition which probably has its foundation during adolescence, characterized by seclusive personality type in individuals who withdraw within themselves. This withdrawal may be due to faulty glandular dysfunction or to psychological fixations in early youth. The individual is what we consider—introverted. There is also a transitory stage between the early introverted personality and the actual psychosis, which may have a duration of a year or two; at times more. The introversion of this type of patient makes him an extremely difficult case to handle, as he does not talk readily and his abnormal trends from his own psychological viewpoint are difficult to obtain. We recognize early that he withdraws from the ordinary interests. As a child his friends are among people who are older than himself and he chooses his friends from those who are particularly kind to him and particularly helpful. Although he is inclined to appear old for his age, yet he is very dependent upon the guidance of others in his life activities. It is extremely necessary in the present civilization that the individual reach adulthood mentally as well as physically, but the schizophrenic personality never seems to be able to arrive at such a stage of independence. Moreover, he explains all of his reactions from an introverted aspect. As a child a schizophrenic is frequently very studious, is usually serious in a gathering of people and is more inclined to quote long passages from Homer than to enter into the spirit of the fun. In simple words he is an asocial individual who is unable to understand the joy of life which should be present normally in all people. He may be an extremely intelligent individual, who even through his introversions protects himself from insanity. His contributions to art and learning may be great. His psychosis develops in adolescence because it is then that the conflicts of society develop and he is not able to handle his instinctive cravings. The patient himself recognizes often that he is slowly losing interest and that he is becoming passive to everything in life.

If, at this time, the condition is recognized, it is possible, to bring about a satisfactory adjustment and a possible cure, providing that the inherent intelligence is there so that the patient can understand his own problems. During the very first stage, he becomes over-careful about his personal self and attempts to force an interest. As he finds that it is more and more impossible to do so, he gradually becomes careless. At a still later stage, he begins to develop a dream-life. The conflict which is going on, due to his introverted attitude and the demands of society at large, forces him to substitute for his mental satisfaction, his dream, and he produces a world as he would like it in his day dreams. These become more pernicious if the ego has not been able to reach a central position in some field.

He then begins regressing to a childish level in which his dreams become more real, and it is in this stage that his insight into his maladjustment is lost. This continues until there is

a complete splitting and the day dreams appear as a reality to the individual. With the regression, there is a loss of emotional tone, and as the condition progresses there is, if not an actual, at least an apparent deterioration mentally, until in the final stages these individuals become mere masses of flesh and blood who are completely shut in; they do not talk, and merely care for the absolutely necessary bodily functions, grabbing at their food and eating it more like beasts. Some of them in their dream-lives develop feelings that people are working against them and they become what is known as paranoid; also there are delusions of reference and in an attempt to maintain the ego the patient blames others for things for which he is responsible. In contra-indication of the condition which we know of—paranoia, the delusions of the praecox are not fixed but change somewhat from time to time, they are bizarre, but they can never be removed by trying to show the patient how bizarre they are. Although in the earlier stages false ideas remain as delusions, as the disease progresses to the patients themselves they become facts.

During the first stages, as mentioned before, treatment is not hopeless. By judicious mental therapy and leading the patient to realize the cause of his maladjustment by arousing his interest in further activity, the individual may be brought back to normal and may make a complete recovery. As the disease progresses, the treatment becomes more and more difficult until when the patient has regressed to the Foetal stage in life, nothing seems to succeed. For this condition, various treatments have been used, such as raising of the bodily temperature, glandular therapy and prolonged narcosis, and much research has been done with varying results. It is also known that remissions have occurred at times, the cause of which has not been determined, but every decade the outlook of this disease is becoming brighter and eventually it is hoped that with the education of the public these cases will all be brought to the attention of the psychiatrist early in the stage of their psychoses so that the condition known as dementia praecox will not be looked upon in such horror as it is at the present time.

The expression mania now means the manic type of manic-depressive psychosis. The leading element is the exaltation of mood, which is easily transformed into anger and which is very changeable. In thought, there is flight of ideas and pressure of activity, also overestimated and grandiose ideas. The patient feels that nothing is beyond his ability. Not infrequently we also find exalted moods in almost all dementing psychoses. The degree of exaltation varies from the mildest exaggeration to the wildest excitement. In the mild forms of this state the psychic activity and mobility of attention are increased. The patient may appear livelier, more capable than formerly. He is witty; he comments on the appearance and also interferes in the affairs of others. There is a "lack of inner unity in the course of ideas." Recollection of recent events is not exact. The patient is easily led away in his narrations to exaggerations. The sexual excitability is increased. This increased sexual desire may lead to embarrassing situations. This mild form of manic state leads to the morbid state of actual acute manic excitement. The onset of this state is always fairly sudden. The hyperactivity is more marked. The speech and acts have characteristics of primitive frankness; they are vigorous and very often violent. Restlessness and marked destructiveness are common. With all this these patients are jolly, but ofttimes become angry, followed by violence. There is an absence of the sense of fatigue or exhaustion and also a lack of consideration of consequences. This is what gives them a superhuman strength. Hallucinations are rare, but delusions occur frequently. The latter are of grandeur and of a religious type, which are produced by them oftentimes in a theatrical manner. In the most severe degrees distinction from delirium may be impossible.

The mild forms of depressive states are characterized by the appearance of a simple psychic inhibition without hallucinations and without marked delusions. In such cases thinking is difficult. The patient cannot collect his thoughts; he is not able to perceive or to follow the train of thoughts of a conversation. He has to consider a long time about simple things. Later, in severe cases, the mood is one of hopeless sadness. He feels solitary and unhappy. Occasionally imperative ideas emerge in these states. There is a total absence of energy. Movements of the body are very slow and limited. He

lacks will power. Sometimes a passion for lying in bed is developed. The patient promises to rise tomorrow, but has always new excuses to remain in bed. Though he is silent and motionless, he often sleeps very little.

Another variety of depression which is more common is the "worried depression." This presents an attitude of anxiety. Here the thoughts are freely expressed, but are limited to certain ideas that conform with the mood of worry and anxiety. The patient walks slowly up and down, moans and tears his hair, and repeats for hours and days: "Oh, my God, my God," or "Won't you kill me, please," or "Let me out, so I may die!" These states of intense restless agitation may last for a long period. Dreams of horrifying content interrupt the short snatches of sleep. This depressive state may reach a very high stage in the negation of everything. In these cases the patients affirm that they "no longer have any family," or "everything is lost," or "the heart no longer beats and the blood has ceased to circulate." They deny their own existence, failing to recognize their own identity. Frequently the patients have ideas of persecution, closely connected with the delusion of sin. The extraordinarily strong tendency to suicide is of greatest practical significance. Sometimes it accompanies the whole course of the disease, without culminating in a serious attempt, owing to the incapacity of the patients to arrive at a decision. Still the danger of suicide is in all circumstances extremely serious, as the volitional inhibition may disappear abruptly. In the severe cases of depressive states the psychic inhibition may develop into stupor.

The manic and depressive states run almost in pure form in the common cases of manic depressive psychosis. But very often we meet with states which do not exactly correspond with either manic excitement or depression, but represent a mixture of the morbid symptoms of both.

Of considerable importance to the state hospitals is senile psychosis and psychoses with cerebral arteriosclerosis. The senile psychosis is characterized by the following symptoms: The first morbid symptom is the change of character. Then the memory fails more and more. The more recent an experience, the sooner it is forgotten. In the course of years, the limits of recollection are pushed back farther and farther, and at last the patients live only in their childhood. In the first year the patients try to act as usual. Then their actions become clumsy, unsteady and finally entirely senseless. There is a lack of thoughtfulness which is liable to mislead them into stupid financial transactions. Frequently they wander about the house or outside, especially at night, without any purpose. To this there might be added hallucinations of experiences of youth. Perception and attention are changed in the sense of the organic disturbance. Orientation becomes more or less disturbed. They do not know what year it is, or the date or the year of their birth. While in this condition the large majority of senile psychoses could and should be taken care of at home or in the poorhouse.

Of importance but possibly of less interest because of its infrequency, are paranoia and paranoid conditions, which resemble the paranoid type of dementia praecox, but in whom the delusion is more fixed and more logical in its structure.

MENTAL HYGIENE SERVICE

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With society as cluttered with misfits as it is at the present time, due to our more complicated modus of living, the need for psychiatric service to the public is increasing at the rate which is becoming more and more difficult to fulfill, because of a lack of personnel and funds. Since these maladjustments in society are frequently the forerunners of the actual psychotic states, it seems only reasonable that the care of such cases would logically fall under the supervision of the state hospitals. We do not wish to underrate those clinics held by various private and general hospitals, as an indirect supervision usually exists, since these clinics are often conducted by men who are or have been closely associated with a state hospital.

Many years have passed since people lived by the law of the survival of the fittest. Now civilization protects the unfit and attempts to strengthen them so that they can successfully compete with those who are inherently strong enough to face the complexities of our modern

civilization. Our general hospitals are well caring for these problems of a physical nature, but it has not been until comparatively recently that the state hospitals have taken over the burden of caring for the maladjustments due to environmental or mental difficulties—those maladjustments which play an important part in the etiology of the psychoses, for those factors resulting in the formation of behavior pattern in children—and in adults, for those preventable characteristics causing legal difficulties. Marital difficulty, poverty, crime, and inadequacy confront the various social agencies; behavior problems among school children are a frequent source of difficulty to the teachers as well as to the parents. Since the normal individual does not fight the social order of living, these people who are at cross purposes with the world, are abnormal to a certain extent. Some of these difficulties are due to environmental causes, many of which can be readily removed; others are due to an inherent personality defect, about which we know very little as yet, but which can be alleviated to some extent by psychic treatment.

Most state hospitals could maintain an outpatient department without materially adding to their staff, yet unfortunately, few psychiatrists have had much experience with the problems of children. It is only during the last few years that special attention has been paid to this branch of psychiatry. This difficulty is being rapidly overcome and it will not be long until every institution will maintain a physician on its staff who is qualified to carry on this work. With the marked personality changes in children, resulting from encephalitis, even the layman can well recognize that behavior may be closely linked with pathology of the brain tissue. Although by far the greater number of behavior maladjustments are not so closely linked with brain pathology, yet this serious condition has made people realize that behavior may be beyond the control of the individual.

Clinics conducted in connection with state hospitals could serve a twofold purpose, that of caring for the paroled cases as well as offering service to the maladjusted people at large. It would seem advisable that a close inter-relation exist between all of these clinics, as the type of case from which these feed is constantly shifting since these people are rather notoriously unstable, ever wandering from place to place—causing frequent duplication in work. The problem is readily solved in a small state where the entire work can be carried on by a single unit under the control of a state hospital which cares for the entire state. There is a considerable amount of confusion avoided and contact is readily kept with all people as long as they remain residents of the state. The same clinic gives service to the various penal institutions as well as the more or less private organizations which care for the dependent. With this rather broad scope of work, the ultimate adjustment of cases can be readily obtained and their progress carefully checked.

There is another important factor to be considered in having such a clinic maintained by the state, and that is the question of finances. State control removes all seeking of funds from private sources and allows the clinic to spend its entire energy on the more important factors—those pertaining directly to the patient.

The education of the public is an important duty in the working of a successful clinic. It is only human that the people should expect immediate results. They do not realize that the pathological condition existing has taken years to develop and that all can not be rectified in a very short time, but that it will take months and even years before satisfactory results can be obtained. This fact does not exist only with the general public but frequently with the more trained workers who bring the patients to the clinic to be examined. Their problems are difficult and they naturally desire a quick adjustment. Delay often results in a loss of contact between the worker and the clinic, unless the worker fully understands the complexity of the problem involved. Also with the small understanding of psychic problems the information which they bring to the clinic about the patients is inadequate, throwing a further burden on the clinic personnel. Until the nature of behavior cases and the early signs of the semi-insane are understood, these workers are unable to obtain the information necessary to the successful handling of a case in the clinic. At the present, the psychiatrist is frequently forced to make a recommendation without the proper information. This is an unfortunate and even dangerous procedure, often resulting in dismal failure. In

later years the necessary training will be a part of the schooling of every worker. Until then, it is part of the burden of the clinic to help in the education of the workers outside of its own personnel, preparing them to help in the ultimate adjustment of the individual case.

The work of a single clinic in a small state becomes very diverse in character. As well as to the special problem cases, and cases in institutions, service is rendered to schools where retardation and class placement is an important factor. This clinic also offers service to all ages so that it is not infrequent to have entire families brought for study. It also controls the sterilization of all cases which are at large, namely: mentally deficient, epileptics and those who have been convicted of three or more felonies, whose behavior is due to abnormal personality makeup, making the preliminary examination and referring those in which sterilization is considered important to the proper authorities. As yet the parole cases have not come under the care of this clinic but it will be gradually absorbed as the personnel increases. This obviates the necessity of paroled patients, living at a great distance from the hospital, from traveling any distance, and for this reason will give the hospital staff a more frequent contact with the out-patients of the hospital, and an opportunity to carry through pre-discharge psychiatric examinations where heretofore it has been found necessary to depend on information obtained from social workers, which at times results in recommitments shortly after discharge.

At the time of considering a state-controlled mental hygiene clinic, careful consideration was taken of border-line cases of a kind who need more careful and continuous study than the type which can be given by attendance at a clinic, many cases not actually insane. Many people suffering from these border-line conditions react well to a hospital residence of a short period where they can receive daily psychic treatment. Other actual psychoses of a few days' duration could well do without actual commitment to a state hospital if there were some institution in which they could stay. With these people in mind, the state built a Psychiatric Observation Clinic, the purpose of whch was to provide hospital residence for patients suffering from mental and nervous conditions without actual commitment to a state hospital. This Clinic of the Delaware State Hospital was opened February 12, 1931.

REPORT OF A CASE OF MULTIPLE MYELOMA

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Multiple myeloma is selected as a topic because it is seen infrequently and in many instances is unrecognized until discovered at autopsy. Such is the case to be herewith reported.

According to Ewing, multiple myeloma is a specific malignant tumor of the bone marrow arising probably from a single-cell type, characterized chiefly by multiple foci of origin, a uniform and specific structure composed of plasma cells or their derivatives, rare metastases, albumosuria and a fatal termination. It comes under the classification of bone sarcomas.

It is pertinent here as a commentary on the definition just given to say that Coley, in the January, 1930, *Annals of Surgery*, gives a series of cases treated with the toxins of erysipelas and the bacillus prodigiosus. He states that it was found that multiple myeloma are highly sensitive to both toxins which, because of their inhibitory action on the growth of the tumors, produces great amelioration of the symptoms and in some cases disappearance of the tumors with apparently a lasting cure. Coley concludes that multiple myeloma should not be given up as hopeless until prolonged trial of both toxins mentioned, and that in many instances radiation has also markedly benefited some cases, either alone or in combination with the toxins.

A perusal of the literature indicates that multiple myeloma was first reported in 1850 under the term mollities ossium, and that previous to 1916 Martini had been able to find only 204 cases reported, and up to 1927 only 405 cases had been reported. The disease apparently does not favor any special strata of society, race, or climate; it is very widespread. The average duration is about two years and death may be due to metastases or anemia. That the disease is of fatal termination is the general opinion. Often the first evidence is an unexplained fracture and it is interesting to note that most of

the diagnoses of reported cases were made at necropsy.

B. C., a Negro, aged 77 years, was committed to the Delaware State Hospital on October 25, 1930. The medical certificate accompanying the patient stated that he had been in his present mental condition for more than one year. Nothing was said of any marked physical defect of any kind. After the usual period of observation the case was presented as a senile psychosis and the diagnosis confirmed by the assembled staff.

Physical examination at the time of admission showed an aged, colored male, height 5 feet 7 inches, weight 165 pounds, inguinal glands palpable, phimosis present, a marked generalized arteriosclerosis with blood pressure 146/44, hypertrophy of the left ventricle, aortic and mitral systolic murmurs and a slight arrhythmia present. Neurologically the skin reflexes were absent, tendon reflexes sluggish, and Babinski negative. Serologically, the blood and spinal Wassermanns were negative, and the colloidal gold reaction 0222000000. Urine examination practically negative, red blood cells 4,380,000, hemoglobin 80%, white blood cells 6,900.

The patient led a normal ward life until December, 1930, when it was noted that he was growing more confused mentally and physically less able to get about.

December 20, 1930, it was discovered that he had a compound fracture of the proximal phalange of the right small toe and at the time it was thought to be due to some unobserved minor accident. Blood chemistry was done about this time and found normal for sugar and urea. Urinalysis showed a light cloud of albumen and a few hyaline casts. From the date of discovery until December 30, the toe was kept in a splint with daily chlorazene irrigations. On the latter date, after a consultation with the superintendent, the toe was amputated under local anesthesia and a gauze drain left in. Two days later the dressings were removed and it was found that a purulent discharge was coming from a small opening between the point of amputation and the adjoining toe. Chlorazene irrigations were re-started and wet dressings of 5% aluminum acetate applied to the infected area. It was on this same day, namely January 1, 1931, that a tumor the size of a small orange was found midway of the left clavicle. It was not freely movable, rather firm and smooth and painful on slight pressure. Also crepitus occurred on pressure and a fracture of the clavicle was suspected, which was confirmed by the xray. At that time three possible diagnoses were thought of as to the tumor, namely, hematoma as a result of the fracture of the clavicle, cold abscess, and lastly, it was considered that it might be a new growth. The laboratory at this time reported the red blood cells as 3,880,000, hemoglobin 65%, and white blood cells as 12,400. The urine contained a cloud of albumen and an occasional hyaline cast. A blood culture was reported as negative for any growth in both 24 hours and 72 hours.

It is interesting to note at this point, that though a new growth was suspected at this time, particularly after the last laboratory report on the red blood cells and hemoglobin showed a marked diminution, it was still unsuspected that multiple myeloma was the causative agent. The fractured toe and clavicle were thought to have resulted from the patient's having stumbled or fallen during some of his confused ramblings about the ward. On January 4, 1931, patient's condition became grave, and he died on January 5, 1931.

An autopsy was performed on January 6, 1931. The bones of the skull were found entirely normal after a careful search for tumor nodules. The left clavicle showed a pathological fracture in its middle third with much bone absorption, pus in the marrow cavity, and about three ounces of thick whitish pus in the surrounding tissues; definite gross tumor process was not demonstrable. There were pathological fractures of the left second and left eleventh ribs with pus present, and nodules in the third and fourth right ribs without fracture. There was a firm tumor mass in the upper sternum, eight centimeters in diameter. Upon sawing through it, bone destruction was found and a soft gray to pink non-en-capsulated tumor mass giving in the gross, the picture of undoubted malignancy. Examination of the vertebrae and other bones failed to reveal any more pathology. Further findings of the autopsy were a chronic adhesive pleuritis, a chronic myocarditis, and a suppurative inflammation of the right foot originating from an osteomyelitis.

The picture was that of a multiple myeloma

and the fractures were due to the growth and metastases of this tumor with an acute osteomyelitis at the points of fracture. The fracture of the little toe without history of injury was undoubtedly a part of the same process. Histologic examination of sections from the tumor in the upper sternum proved it to be a plasma cell myeloma.

As to the pseudo-luetic curve of the colloidal gold reaction in this case, it is interesting to note that in the literature at hand, nothing is said as to any change in the spinal fluid. It is reasonable to suppose, however, that the increased albumen in the urine as shown by the Bence-Jones bodies might be duplicated in the spinal fluid by way of the choroid plexus.

The only conclusion to be drawn from this case would seem to be merely confirmatory of the experience of others, namely, that multiple myeloma is often unsuspected and undiagnosed until necropsy.

PROBLEMS OF CHILDREN

By CLAUDE UHLER, M. D.,
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The problems of children do not confine themselves to the home. At an early age the child becomes a factor in community life. On the surface, growth and education seem to take place mechanically without special direction. It is the distinction between the child and plant life which accounts for the consideration of the healthy child as a dynamic figure of inestimable possibilities.

The child is a product of inherited qualities and external influences. From the stage of impregnation of the ovum, at the beginning of the intrauterine period, through birth, infancy and puberty there are at work distinct forces shaping the individual to properly fill his place at maturity.

It is apparent to those who have observed the baby, even during the first few months, that certain behavior is exhibited which cannot be explained as instinctive, but must be attributed to external control. Reactions to feeding and elimination are subject to wide variation, dependent upon general management.

Recognition of persons takes place before it is ordinarily realized. Customary approaches to the cradle, carrying and handling are reflected in the attitude of the infant toward members of the family. In the gradual perfection of special senses, stimulation is afforded in the form of toys and pictures to guide a growing curiosity. Preference is observed for the doll or ball; likes and dislikes are to be reckoned with.

The pre-school age is a fruitful one for habit formation. Not only the fundamental feeding and sleeping habits, but also habits of attention, application and performance set in as a foundation for the special training period just ahead.

The first days at school are not merely an occasion for getting up on time and wearing a new suit and a clean face; it is the time of critical adventure with heavy demand on the child's resources. Very few start with a happy outlook and enjoy the proceedings. Many moments of anxiety and fear dominate the first few weeks of departure from mother. Fascination and interest alternate with timidity and shame. No little shock is attached to the experience alone of having to ask to leave the room.

The teacher witnesses all types of behavior. She rejoices in the individualism of her charges. Not two alike! Strikingly different features, manners and taste! At this point arises the opportunity for securing happy group adjustment. One child recoils on correction, another is angry and rebels; still another is prompted to repetition and satisfactory performance. There finally appears, in the group, conformity to regulation and discipline.

Granted that all the children in the school room are ably equipped with intelligence and health, there will still be manifest varying degrees of disappointment, disagreement and failure, dependent upon differences in effort, attitude and temperament. A happy child in the class room, at peace with his neighbor and attentive to the preliminary tasks, is a genuine source of pleasure, not only to the mother who is ushering him out on his path of emancipation, but also to his teacher who accepts him in the raw state and prepares him for group work. Both parent and instructor share the responsibility for normal progress. They co-operate to help him meet his first real problem.

The importance of leisure is evident in the work of the pupil. Time for play affords needed relief. Just what form of amusement gives the

greatest satisfaction can only be determined from the child's choices. Little restriction is placed on the choice of play, apart from those activities involving physical injury. The teacher knows that direction of choice is a matter to be handled by those who know the child best. Rarely is an attempt made to limit a child at play in the exercise of his taste. Instead, opportunities are provided and fancy has its day under appropriate guidance. Even at these moments of freedom on the playground the child is beset with frustrations and self-denials. It is a new experience when things must be shared, or when it is not his "turn," to say nothing of the rude awakening to the fact that his name is not "Harvey" or "Arnold," but "Skinny" or "Popeyes."

The home enjoys the biggest chance to give the child his due heritage. The physical characteristics of the home mean something, but little as compared with the devotion of parents. In almost mirror exactness the atmosphere of the home is reflected in the reactions of the individual to the affairs of the day. A temper outburst is not dropped from memory. A distracted mother may hastily impose her own conflicts upon the personality of the child and then sometimes wonder at the child's skepticism toward her. Disagreement between parents is a source of pain to children; they carry vivid recollections out with them in competition and play with their fellows. The comfort of a loving parent and a stable home carry the little fellow through many adversities.

The age of puberty, frequently without warning, brings a string of novel experiences. Not only the physiological process, but also new sensations and a wealth of imagery obtrude themselves into consciousness, and bring pressure upon formed habits of reaction. The normal boy may begin to engage in activities foreign to previous customs and, as far as he knows, at variance with conventional standards. A greater range of emotional tone colors his attitudes. He becomes aware of conflicts. He develops reactions of shame and defense. He has feelings of insecurity mingled with urges to explore and conquer. Chance associations and unbridled impulses combine to disorganize the whole personality. In the final evolution, youth takes the permanent form of humane understanding and self-assurance, with an appreciation of the powers of self-control as paramount to ability to do and make things.

In an analysis of conditions that contribute toward this or that behavior, no single set of circumstances may stand out as of major importance. From a brief survey of the child through its stages of development, it is clear that a long list of factors may play a part, such as heredity, infection, injury, education, family background and associations. There may appear traits of character not altogether in harmony either with hereditary forces or with training.

A study of the reaction type may lead to the discovery of mental peculiarity or aberrations not at first apparent. Such variety of individual makeup and environmental forces does not permit predication of one type of behavior to a sole contributing agent. By an investigation of the life charts and the determining of the relative importance of influences, a judgment is reached of value in successful approach to the problem. Arbitrary disposition of a case on the basis of formula or preconception can hardly be expected to permanently remove the problem.

The child presents in his growth from infancy to adolescence opportunities for the prevention of misfortunes. It is his birthright to enjoy physical comforts at infancy and protection against disease. Education and training are supplied in accordance with his abilities. Empirical knowledge provides some defense against economic reverses. Just as vital to his future welfare is a security against unhappiness and social failure.

THE OBSERVATION CLINIC IN DELAWARE*

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It is a universal law that the most highly integrated functions of vital organisms are the most apt to suffer derangement. The human mind, as the most highly developed function of the most wonderfully complex of all organisms, the human being, has always been subject to partial or total disintegrations.

The history of insanity is divided by Kellogg

* Read by title before the Medical Society of Delaware, Wilmington, October 14, 1931.

into four periods—the first from 1700 B. C. to 400 B. C. Egyptian hieroglyphics record that at that remote period, insanity was recognized. It was interpreted by them to mean a divine affliction which called for great sacrifices for its cure, and oblations, incantations, purifications and what not were the methods of approach. King Saul in 1063 B. C. is the first recorded case of homicidal mania. He removed his clothes and remained naked day and night. During a period of mania he attempted to kill David by throwing a javelin at him. King Nebuchadnezzar became insane in 569 B. C. He believed himself to be a wolf and wandered for years in the woods until his body became covered with a heavy growth of hair. Even at this period cures were recorded, for Nebuchadnezzar recovered his reason after seven years, and was restored to his throne in 563 B. C. Cleomenes, King of Sparta, was the first recorded case of alcoholic insanity. The etiology of insanity at that time was based on vague changes in the bile, mucus, and other secretions, and the treatment consisted of games, baths, and mineral waters.

The second period dated from 400 B. C. to 200 A. D. Hippocrates was born in 460 B. C. He first conceived that the brain was the seat of insanity. He was an accurate observer and his statements relative to insanity are applied today with recognized truthfulness. He keenly ridiculed religious ceremony in the treatment of insanity and agreed with philosophers of the day that insanity was a disease of the soul which resided in the head. For treatment he resorted to bleeding, purging, emetics, counter-irritants, mineral waters, baths, music, travel and change of climate. Galen, 200 B. C., next to Hippocrates, was the greatest medical writer of the Greek School, and made some real additions to psychiatric service as it then existed.

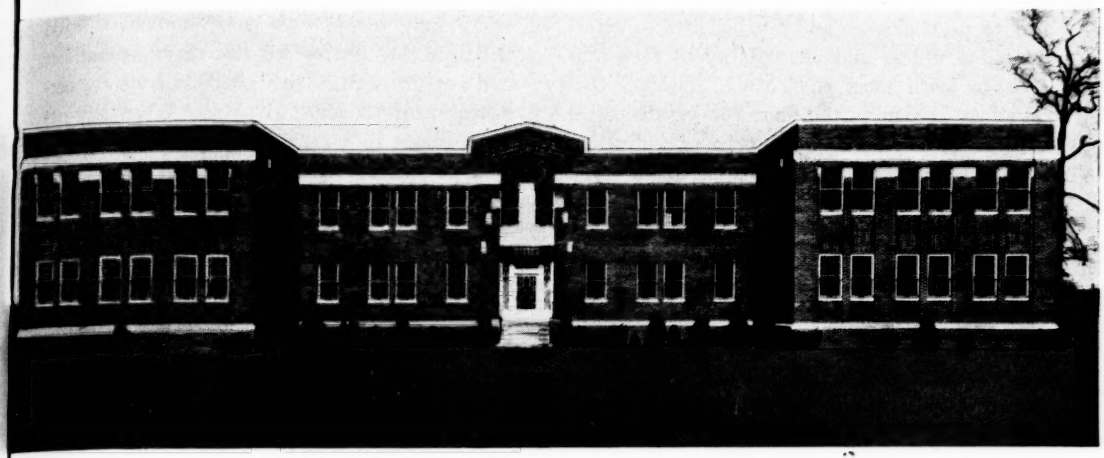
The third period dates from 200 A. D. to 1500 A. D. This was known as the dormant period of psychiatry, for with the decline of the Greek School, much that was known before was forgotten or perverted. Pneumatists, dogmatists, empiricists, and other medical sects arose and discussed such worthless technical theories as have always been the bane of true medical science. Every form of charlatanry came to abound in all parts of the world. The insane wandered, or were driven, from place to place, and hundreds died of neglect and starvation. With the teachings of the Greek School forgotten, the reign of ignorance and superstition in regard to insanity became general. The insane were regarded as possessed by the devil, and their symptoms were mistaken for wilful demonstrations of wickedness. They were treated accordingly in prison cells. Thousands of insane people wandered about, as all hands were raised against them. At the same time, the fanatical belief in witchcraft arose and hundreds were tortured and killed under the influence of that superstition. It is estimated that over one hundred thousand people were burned to death as witches from 1400 to 1700 A. D. It was not until 1500 that the first structures were built in Italy for the reception and treatment of insane. Similar institutions followed soon in England and Belgium.

The fourth period considers the status between 1500 and 1800 A. D. In sympathy with the general revival of knowledge, science, art and literature, psychiatry underwent a rapid evolution.

F. Platter in 1600 made a complete classification of mental diseases and added much to the orderly methods of study. Paul Zacchias (1659) wrote the first complete treatise on medico-legal relations of insanity. Prosper Alpin (1553) described water treatment in mental diseases, and inaugurated our present hydrotherapeutic methods. V. Chirrugi (1759) advocated humane treatment of the insane and the non-restraint system. Thomas Willis (1675) recognized insanity to be the result of brain disease. He employed heroic treatments by powerful drugs and mental shock, and did not hesitate to use severe punishment in violent cases. Denis in Paris (1667) performed a transfusion in a case of melancholia with success. Other men contributed notably to the advance of the science.

Benjamin Rush at the same time spent the force of his genius in bettering the conditions of the insane in America. Phillipe Pinel, who died in 1826, worked his great reform in behalf of the insane at the Bicetre in 1793. He was the first person to urge that mental disease be considered as any other disease of the body and therefore in no way involving any stigma.

Institutions for the care of the insane were



Psychiatric Observation Clinic of the Delaware State Hospital

gradually improved and the number greatly increased. Cruel forms of restraint were largely abolished and a gradual improvement in the general condition and care of the insane has been effected.

Thus we see, in a superficial way, how that portion of medicine known as psychiatry has evolved out of the most primitive conception, based on ignorance and superstition, into what we regard today as a field of artful endeavor guided by the progressive methods that characterize all other divisions of scientific medicine —a little slower in developing, possibly, than some other branches of medicine, because of the complexity and abstract qualities of mental physiology, but reaching its stride, now that superstition is being eradicated, and displaced by scientific investigation. We would not lead you to believe, however, that this evolution has been complete, for we are woefully reminded, not infrequently, of the ignorance that still abounds, not only in the minds of the laity, but in the minds of many of the medical profession itself. One could hardly expect that the layman would be intelligent concerning a matter involving such profound principles as those of metaphysics, philosophy, and psychology, which are so inherently a part of the mind and its processes, and it is probably well that they do not, for a smattering of knowledge on such subjects would add immensely to the present alarming number of neurotics. But in the case of the scientific man, the knowledge of the principles of psychiatry and their importance, as they affect *every* branch of the practice of medicine, should be considered as indispensable, and its value fully recognized. The body and mind can no longer be successfully considered independently. The mind and its relation to the physical is no longer a hypothetical conjecture, but a proven reality, and the doctor who does not know this, or knowing, is unwilling to consider it in his treatment, is cheating himself of a great satisfaction that would come with the proper adjunct of psychiatric knowledge and depriving the patient of the utmost that could be done in alleviating his ills.

I do not feel bold in predicting that in the next ten years the group clinic that tries to practice medicine without a competent psychiatrist will be considered as incompetent and as much out of date as the present clinic without its surgeon or a man on internal medicine. The field of psychiatry is broadening so rapidly as to include not only the treatment of mental diseases, but also its prevention, by the introduction of psychological methods, in the life of every individual from the time he is old enough to be cognizant of his surroundings, to the time he is laid to rest. The wayward child, the backward child, the child with criminal tendencies, with temper tantrums, the genius, all are psychological problems. Even the so-called normal child will become best adapted to his environment under training built on psychological principles. Schools are rapidly inaugurating the services of

trained psychologists and psychiatrists to determine the fitness and adaptability of each student to learn most efficiently. Business corporations recognize the value of psychological methods in determining the type of individual who will be most efficient in a particular type of work, thereby saving time and millions of dollars that were wasted in the old trial and error method of employment. Authorities on crime and prison work are rapidly recognizing how deplorably inadequate the past and present methods have been in dealing with the nation's crime problems and have already in many points of the country employed full-time psychiatrists to correct the evil. Everybody everywhere is gradually beginning to realize that if he is to make the most out of life, he must abide by the laws which govern his conduct, and these can be understood only through the psychiatric approach.

The value of the psychiatric consideration of a patient in the practice of medicine can be illustrated by the following case: A female, about 40 years old, is married and has a child 15 years of age. She developed a group of symptoms which led to a gastro-enterostomy, performed by an excellent surgeon at one of Philadelphia's very best hospitals. The operation was a success but the patient did not get well. Ten years later the gastro-enterostomy was obliterated and duodenal physiology restored. Still the patient did not get well, and for the past six months or more has presented a typical gall bladder syndrome, on account of which another operation was seriously considered. Since coming under our observation we have discovered some very significant facts, which were entirely overlooked in previous histories. This patient when about 20 years old stepped accidentally into a man-hole, and suffered a rather severe injury when the man-hole lid struck and wounded the vagina. Inquiring closely into her sexual history, we found a very complicated and deep-seated mental complex, which had been responsible for ill-adjusted marital relations and the subsequent development of a malignant neurosis, with a very poor prognosis, because the mental element was not recognized twenty years ago, when she first consulted the surgeon. If treatment for the mental condition had been instituted at that time, the patient would undoubtedly have been well and happy today. As it is, she has suffered the agonizing distress of two major operations, and endures mental anguish daily from the persistent neurotic physical pains. When any patient comes to you and tells you that she has been to this doctor and that doctor, and volunteers detailed information of diagnosis and treatment in her case, you will be wise to stop, look and listen. Those are warning signs, which should lead you to explore the mind before you advise exploring the abdomen.

The necessity of early diagnosis and treatment is evident. I have said that the prognosis in the cited case was poor. Such a prognosis is not to be wondered at. One might just as well try to teach some one to play the piano backward after he had been trained to play it in the usual way for 20 years. It would be a difficult and tedious task, if not an impossible one. It is no less a task to train a person to think in an entirely different way than he had been used to thinking for 20 years. To effect a change the first few weeks after the fault has arisen is a comparatively simple procedure.

A definite responsibility rests with you, as practitioner, in whatever field of the healing art you may be engaged, in recognizing the early manifestations of mental disorder in your patients. When this responsibility is recognized and assumed, the terrible bugaboo and unjustified pessimism that is abroad today in the minds of so many who think that a person once insane is always insane, will have been eradicated, for then, and only then, will we be able to find these cases in their incipiency and cure them while they are still considered as cases of nervousness, and do not carry the stigma that is associated with the late stages of insanity. Already there is a growing tendency to that end. Our relation to the insane is no longer simply the care of chronic degenerate custodial cases of insanity, and the modern, progressive hospital for mental cases is no longer a custodial institution for incurables. The modern conception of psychiatry and methods of treating mental cases demands a hospital equipment and organization of the first order. The idea so prevalent, that a person once suffering from a mental disease must continue to suffer for the rest of his life, is no more true than the idea that a person afflicted with tuberculosis or cancer is doomed to death.

A certain proportion of mental cases is incurable, just as certain cases of cancer and tuberculosis are incurable, but the proportion of cures in mental disease is shown by reliable statistics to be every bit as good as that of either of the other two. Cancer, if it could be recognized in every case in its incipiency, is practically 100% curable. The early recognition and treatment of mental disorders is no less essential for successful treatment than for cancer or tuberculosis.

With these factors before us, we have come to recognize the necessity for certain changes in the care and treatment of mental cases. To begin with, may I make the point that it is necessary to know that many people who are suffering from mental disorders are not insane. Frank symptoms of insanity may be considered in a sense, as evidence of an *advanced* pathological change. Practically every case of insanity, if the history is carefully taken, presents numerous bits of evidence that foretell the impending breakdown. These symptoms are often recognized by members of the family, or the attending physician, but because of the failure to recognize their importance, they usually demand very little consideration, and are passed on with the despairing hope that in some way "God will take care of you!"

In saying that I do not mean to intimate that the doctor is always guilty of neglect or indifference. I am aware of the fact that if he did recognize those tell-tale symptoms he would often hesitate to mention them to relatives for fear of insulting them and at the risk of losing the case to a less audacious doctor. "My daughter or son insane! Preposterous! Impossible! A downright insult. Insanity? Why, that's a disgrace. The insane hospital? A still greater degradation. A place despised, shunned and pointed out from the roadside as a pitiable, deplorable institution which housed only degenerates and maniacs. A place from which, if a person ever emerged, he emerged with a shame and stigma no less than that imposed by the penitentiary itself. What respectable person would ever consent to sending his loved ones to such a place? Don't tell me my child is insane." And with that fear in the public mind, the patient is allowed to progress until he becomes so depressed that he attempts suicide or in other ways becomes unmanageable at home. Then, with tears in their eyes, and with a forlorn look more suitable for a funeral, the relatives finally give in to the terrible humiliation of sending him to the so-called "insane asylum."

But there is a ray of hope. Things are changing, though it be slowly. We are teaching people that mental trouble is a disease, in no essentials any different than disease in any other part of the body, and that as such it carries no stigma whatever. We are trying to impress upon them the fact that it is a curable disease and that thousands of people, once actually insane, have been restored to full usefulness and happiness and that many thousands more could be prevented from becoming insane if they would only seek advice and treatment soon enough. The medical profession here again has a definite responsibility. It is known that from 80% to 90% of every doctor's patients, no matter what specialty he may practice outside the field of psychiatry, presents a significant mental problem which should have a definite consideration in prescribing treatment. It is your duty to talk intelligently to your patients about those problems. The patient will then become accustomed to consider his mental attitude as a part of his disease and will not be shocked into insensibility by discovering, after years of mental suffering, that the doctors, all those years, have been fooling him, have taken all his money, treating him for every conceivable disease and given him no relief. He finally comes to the pathetic realization that he is insane. We, the psychiatrists, beg of you, as medical men, to become more intensely interested in this great field of medicine, no more important than surgery, or any other branch of medicine, but equally as important as any.

Recognizing the importance of recognition and treatment of early cases in such a way as to avoid the popularly conceived stigma of commitment to an insane asylum, legislation was sought in the state of Delaware which would permit the establishment of a state-controlled observation hospital, into which patients could be admitted, treated, and cured without ever having been legally adjudged insane. The effort to obtain such legislation was successful, and on April 8, 1929, the following law was incorporated in the statutes of the state of Delaware.

An Act authorizing the establishment of a

Psychiatric Observation Clinic at the Delaware State Hospital at Farnhurst.

Section 1. The State Board of Trustees of the Delaware State Hospital at Farnhurst are hereby authorized to establish under the direction and supervision of the said State Hospital, a psychiatric observation clinic for the observation, study, psychiatric diagnosis and treatment of persons suffering from mental and nervous diseases. Any physician licensed to practice medicine within this state may, upon compliance with the rules and regulations of the said State Board of Trustees made from time to time, cause any patient under his care and treatment, who is suffering from mental or nervous disease, to be admitted to said clinic for a period not to exceed four weeks at any one time for observation, study, diagnosis, and treatment. Any patient so admitted shall remain in said clinic for a further period or periods not to exceed four weeks' duration each, upon the request of the physician upon whose application such patient was admitted to said clinic and with the approval of the said State Board of Trustees. Any person who shall be admitted into such clinic shall not be allowed to depart therefrom prior to the expiration of such four weeks' period, or any extension thereof, in case any such extension shall have been made, without the consent of the superintendent of the Delaware State Hospital.
Approved April 8, 1929.

By wise and judicious foresight the lawmakers of the state appropriated generously a sum of money sufficient to build and operate our present Observation Clinic. With the opening of this clinic in February, 1931, a precedent was established in the United States for this type of accommodation for the treatment of mental cases. A statement from the American Medical Association, Council on Medical Education and Hospitals, says that so far as they know, there is no other clinic of a similar nature operated in the United States in connection with a state hospital. The County Hospital at Milwaukee, a hospital for acute mental diseases, receives patients by writs of detention, and by commitment. Patients received by these writs of detention are kept for a few days or a few weeks for observation and treatment and returned to the community without ever having been committed. So far as they have been able to discover, this is the only similar clinic in the United States, and it is under the auspices of the county rather than the state.

A building accommodating forty patients has been fashioned and equipped in accordance with the most recent and most highly approved principles of hospital construction. All but four rooms are private rooms. These four accommodate two patients each. Each room is equipped with the best type of hospital furniture available, and decorated with the prime consideration of creating a pleasant, restful environment, which we recognize as an important factor in the treatment of our cases. The building is serviced with a large, modern kitchen, directed by a graduate dietitian, who plans and directs the preparation of each individual diet. Frigidaire provides dependable refrigeration for all foodstuffs and produces ice-cold drinking water in all parts of the building from drinking fountains of the angular jet type, the only type recognized as safely hygienic. Radio entertainment is brought to all lounging rooms and can be controlled either from a central unit or at each speaker on the ward. One doctor is in constant attendance, and occupies an apartment in the Observation Clinic building, thus making constant supervision of his cases possible with the least inconvenience, and the greatest efficiency.

The patients are cared for by graduate and student nurses, assisted by a corps of attendants trained in every phase of their duty. The selection of these attendants is made only after a very thorough physical examination to determine their physical fitness, and a psychometric examination, which allows us to choose only those who show the desirable personal qualities which fit them for their important work. Classes are conducted throughout the year for the special benefit of these attendants and diplomas granted at the end of the year to those whose record and adaptability have proven them capable and efficient in their duties. This procedure applies not only to the Observation Clinic but to the entire Hospital.

Occupational therapy classes are conducted daily by trained workers.

The clinic is provided with a dental unit of the highest quality obtainable, and a dentist on our visiting staff from the city makes bi-weekly visits to the clinic, rendering the same high-class service that is given in his downtown office. A bedside xray unit permits practically any type of xray work that may be indicated. Separate hydrotherapy units for male and female patients are designed to give continuous baths, packs and sprays. Sound-proof rooms are incorporated in each unit. These rooms are insulated with sound-absorbing materials, so that the minimum of noise from any disturbed patient is allowed to escape from the room. Many other features reflecting

the latest development in hospital construction are incorporated in what we consider a unique institution, all of which we are very proud to exhibit to any of you who feel it worth your while to visit us.

Now, what happens to the patient? In the first place, the clinic is not intended to treat insane people. It is intended to provide a place where any person suffering from mental or nervous difficulties of any kind can come for observation and treatment. The patient is not committed as an insane person, and retains every legal right that he ever possessed. He is hospitalized voluntarily, on the advice of his physician, and remains until, by observation and study, we agree whether or not the patient is able to return to his former occupation.

On admission the patient is put to bed immediately, just the same as though he were suffering from an acute gall bladder or appendix. A complete physical examination is made at once, and a preliminary conference held with the patient, with the purpose chiefly of putting at rest any unnecessary anxiety, to establish the patient's confidence, and to discover any physical condition which might need immediate attention. Then, as rapidly as the patient's condition warrants, certain routine procedures are carried out. The teeth, chest, and head are x-rayed. Urinalysis and blood Wassermanns are taken. Blood chemistry is done, particularly blood sugar and blood urea determinations. Spinal fluids, examination, basal metabolism determinations, psychometric tests, and electro-cardiographic tracings are taken where indicated. A physiotherapist administers treatments from the quartz mercury lamp, infra-red, diathermy, sinusoidal, galvanic and farodic high frequency current.

A staff of twenty men, all specialists in their line, residing in Wilmington and Philadelphia, compose our consulting staff, and their services are at our command as we wish. And all this at no extra cost to the patient! Work that would cost from $100 to $500 under any other circumstances.

Now, what does the patient pay? He may pay absolutely nothing, or he may pay $50.00 a week. The clinic cannot be a money-making institution, since our fees in no instance are sufficient to cover more than a small fraction of the actual cost of caring for the patient. Our social worker, while investigating the family environment and other factors relative to the patient's mental trouble, also tries to determine their ability to pay, and we charge accordingly.

During the first four weeks of the patient's residence in the clinic, we study the case and analyze our findings. At the end of the period, a comprehensive summary is made, the case is presented at a staff meeting, with all staff members of the hospital present, and a diagnosis made if possible. If not, an extension of the observation period is requested of the Board of Trustees, the patient's relatives and family physician, and our study and observation continue. It goes without saying that some cases require a much longer time than others. Even if we arrive at a definite diagnosis, and find that a patient is suffering from a psychosis which we have reason to believe can be cured in a comparatively short time, we hesitate to advise committing that patient as insane as provided by the law, but rather prefer to extend the observation period sufficiently to allow recovery, thus sparing the patient the disagreeable status of having been declared legally insane.

If, after the observation period, we decide that the patient is insane and requires prolonged treatment, he is legally committed to the hospital proper as insane. If no psychosis is discovered, or if the patient has recovered sufficiently to allow an adjustment away from the clinic, such a dispensation is made. In such instances our interest does not stop with the dismissal of the patient, but he is instructed to report personally at the clinic at least once a week, so that we may know to what extent his adjustment is satisfactory. If he does not report regularly, our social service worker calls at his residence or visits his employer and gets the desired information.

In short, the object of the Observation Clinic is to provide a place under ideal circumstances where a patient may have his mental ills adjusted without being made subject to the restrictions of legal insanity and without suffering the moral stigma of confinement in a hospital for mental diseases, with the accompanying shame and disrespect that is, unfortunately, still so frequently assumed by many people. By this provision, we are hoping that we have established a wise departure in the matter of alleviating the mental

ills that are prevalent in a rapidly increasing percentage of our population. We are hoping that we shall be able, in this community at least, to convince the people around about us, in this practical way that all ugliness, shame and hopelessness that have been so long the only conception that they have ever had of a hospital for mental diseases, is purely a delusion, and in its place to plant a picture more truly representative of the humanitarian effort and the scientific progress which the institution represents. We are hoping that we shall be able to make people feel that it is no more of a disgrace to be treated for mental illness than it is to be treated for appendicitis, and that before long the young lady will be as proud to tell of her mental recovery as she is to exhibit her appendectomy scar.

I have thus tried to outline the origin, intent and practical working of the Observation Clinic of the Delaware State Hospital at Farnhurst. To us it seems a definite advance in the care and consideration of those mentally ill. To some of you it may appear a foolhardy and wasteful expenditure of money, but we do not feel in the least apologetic. In fact, we are proud to be the pioneers in such a progressive undertaking, and we sincerely hope that you will take advantage of this new service placed at your disposal by this state.

A CASE OF PSYCHOSIS DUE TO ORGANIC BRAIN DISEASE (BRAIN TUMOR)

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Brain tumor, as an entity, is not rare, as far as neurological pathology is concerned, but cases in which brain tumor produces a psychosis, making it necessary for them to be treated in a mental hospital, are possibly not so common.

This case is presented for whatever interest it may possess in the matter of symptomotology, diagnosis, treatment and prognosis.

The patient was a male, 52 years of age; a Grecian by birth; a resident of the United States for the past twenty years; a laborer by occupation. He was engaged in hauling rubbish at the time the accident occurred which it was thought may have precipitated his illness. He was considered by acquaintances as a man of good character and habits, did not use alcoholic beverages, and was always even tempered. He was married to a native Greek woman, and five children were born to the union. The youngest of these children died of pneumonia while the father was our patient. The others are normal children. No history can be obtained of nervous and mental disease or cancer in the family. He had no serious illness at any time prior to the onset of the condition under consideration.

On February 27, 1931, the patient was engaged in carrying rubbish from a cellar. While walking up the cellar steps, one of the cellar doors, made of sheet steel, fell on his head. He was "stunned" (lost consciousness) for about five minutes, but the scalp was not cut and the patient proceeded with his work without going to a doctor. In about a week he complained of pain in his head and complained of being weak. On March 24th, about one month after the accident, the family noticed that he was doing peculiar things, such as putting his shoes on the wrong foot and trying to cut bread with the wrong edge of the knife. He became confused and wandered around in a daze. He was taken to an ophthalmologist, in the belief that his confusion was due to his eyes. He was fitted with glasses, but did not improve. He consulted another doctor, who stated that he had evidence of a light stroke, and he was sent to a hospital for xray examination, which was reported negative. The diagnosis of hemiplegia was made, and patient remained in the hospital for six weeks. He was discharged as improved. He was taken home and put to bed. Frequent fainting spells developed, headache became more constant, and weakness continued until the patient could not walk.

He was brought to the Observation Clinic of the Delaware State Hospital on June 1st, 1931, less than four months after the accident. On admission he was a little confused and somewhat talkative, but was well oriented in all spheres and answered questions relevantly, with some lack of spontaneity. He was unable to stand alone, and had to be assisted in all his activities. Five days after admission he became obviously hallucinated, talking loudly toward the window, as though talking to someone outside. These

hallucinated periods lasted for about 24 hours, and subsided, to reoccur two or three times later during his period of illness. He very seldom complained, except with reference to his headache. His appetite remained good, and there was no vomiting.

The neurological findings on admission were as follows: moderate weakness in both left extremities; pupils round and equal, but very large, and did not react to light; lateral nystagmus, with a quick component to the right; impaired vision on both sides, but the extent of the impairment could not be determined with perimeter tests because patient would not cooperate; a choke disc of about two diopters was present in each eye. All other cranial nerves showed no involvement, unless we might consider the auditory hallucinations as evidence of eighth nerve stimulation. Light touch was impaired on the entire left side of the body except the face, where it appeared to be normal. Sense of pain was diminished on the left side. Sense of position was unimpaired. Patient always fell backward when permitted to stand alone. Patellar reflex was exaggerated on the left side. Ankle clonus was active on both sides, more so on the left. Babinski positive on the left. There was a moderate tremor of the extended hands, equal on both sides. The tongue protruded in midline and facial mimicry was normal. Corneal reflexes were active on both sides.

Laboratory work gave nothing of diagnostic value. Serology of both blood and spinal fluid was entirely negative. Spinal fluid pressure was between 20 and 25 mg. mercury. Urine showed an occasional hyaline cast. The blood urea was 17 mg. per 100 cc. blood. Xrays were all negative. (Details of laboratory work are omitted for brevity). Temperature remained within normal limits until shortly before his death.

The symptoms and signs of the condition, although apparently improving in some respects on different examinations, maintained on the whole a progressive course. The choke disc resulted in complete blindness, the left-sided weakness increased, the hypoesthesia remained prominent and the deep reflexes remained exaggerated, increasing on the left side. The Babinski toward the end was not so easily elicited. Vomiting occurred only once, a few hours before death.

Brain tumor, brain abscess, tuberculosis, and vascular condition were considered in diagnosis. A vascular condition was believed possible because of the history that there had been frequent periods of remission, which it was thought would most likely be due to vascular changes. Brain tumor and brain abscess were not definitely differentiated because of the lack of differential signs and symptoms. In the absence of any demonstrable focus of infection or infectious symptoms, brain tumor was considered the most likely diagnosis, and because of light paresis on the left side (contralateral), increased deep reflexes, with positive Babinski and contralateral hypoesthesia, the tumor was tentatively localized in the right temporal lobe.

Autopsy verified this diagnosis. A tumor, non-encapsulated and somewhat necrotic, with a left to right diameter of 5.5 cm., an anteroposterior of 7.5 cm., and a superior-inferior of 4.5 cm. was found in the right temporal lobe. The pathological diagnosis was glioma of the brain.

COMMENT

There are one or two points in this case that may be worthy of special consideration. The

difficulty of diagnosis and localization in such cases is, of course, always fraught with dangers of error, and besides the usual difficulties in this instance, the history of remissions proved an additional stumbling block not ordinarily met with, thus forcing us to consider some variable factor which we thought might be either tuberculosis or vascular pathology. Whether these remissions were actual or only apparent is difficult to say, but autopsy failed to reveal any reason for them to exist.

The rapidity with which the tumor developed was unusual, and of some medico-legal importance in this case, because of the possibility of attempting to fix responsibility for the death. Trauma has been considered for years as a possible cause of brain tumor, but the proof of such an hypothesis must always be circumstantial, since we know of no definite evidence of such a relationship. In this case it might be argued that the symptoms developed so soon after the accident that the tumor must have been there before the trauma occurred, but the man had been unusually healthy all his life, had no hereditary background for cancer predisposition, and with the symptoms starting and progressing so definitely from the date of the accident, we have hardly a choice, from a clinical viewpoint, to consider anything but a direct relationship.

A question also arises relative to the most judicious form of treatment. Surgery, of course, was considered from the beginning, and very seriously, indeed, since the man had a wife and five small children as dependents, and there was no provision for their welfare in case of his death. But localizing symptoms were very uncertain, and the rapidity of the onset suggested a rapidly growing tumor of the gliomatous type, which we recognized as being unoperable because of the failure of that type of tumor to encapsulate. We decided, therefore, in spite of the insistent urging of friends and relatives, not to add to the unpreventably high surgical mortality in the most favorable of such cases, our decision in this regard being fortified by the opinion of Dr. Charles H. Frazier, of Philadelphia. The treatment was entirely symptomatic.

A CASE OF MULTIPLE OR DISSEMINATED SCLEROSIS

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Multiple sclerosis is described as being a chronic affection with patches of sclerosis scattered throughout the central nervous system. These sclerotic localized areas vary in size and form. There occurs a formation of glia tissue and degeneration of myelin. A degenerative process and inflammatory change due to a spirochete are considered as possible etiological agents.

Multiple sclerosis is not considered now so infrequent a disease as had been suspected previously. There are many factors connected with it, that render its diagnosis so uncertain. It was therefore considered advisable by the Association for Research in Nervous and Mental Diseases, to conduct a series of investigations and reports. This resulted in the publication of a monogram on the subject in 1921. The conclusions arrived at, have rendered the recognition of this disease with its poor prognosis, more illuminating.

The important facts determined upon indicated that it is among the most common organic diseases affecting the nervous system. It occurs in all ages, from early childhood to old age, but is most common between twenty and forty. The average duration is seven to ten years.

Based upon the study of 141 cases, Sachs and Friedman regard that the diagnosis may be safely made if the following important symptoms are present: Gradual development of weakness, easy fatigue, stiffness of one or both upper and lower extremities, resulting in spastic paraplegia—associated with increase of deep reflexes positive Babinski sign nystagmus, ataxic tremor, loss of abdominal reflexes, ataxic gait, scanning speech or some form of dysarthria, pallor of optic discs, emotional instability, unusual remission, diplopia, sensory disturbances, mental changes, auditory nerve involvement. Cadwalader and McConnell state that if in a given case of spastic paraplegia, intention tremor, scannning speech, optic atrophy, nystagmus are present, the diagnosis presents little difficulty. These symptoms point to an advanced stage of the disease. In the earlier stages, the diagnosis is exceedingly difficult.

Birley and Dudgen have shown that most cases run an intermittent course.

Brown and Davis mention euphoria as most frequent mental symptom occurring. Although suffering from a serious disease, they do not think of their condition as serious nor do they seem deeply concerned about it. Deterioration may or may not occur but is probably present in a majority of cases. Delusions and hallucinations may also be present.

Alger and Foster report on 38 collected cases in regard to spinal fluid study. In approximately half of the fluids there are pathological changes. Foremost is paretic gold solution curve. Protein is normal or only moderately increased. The cell count is usually low or slightly increased. Wassermann is negative.

In this case, C. R., female, age 48, was admitted to the Delaware State Hospital, November 13, 1930.

Family history—negative.

Personal history. Always in good health with exception of pneumonia at age of twenty-two with an uneventful recovery.

Onset. Five years before admission, complained of dizzy spells, sudden blackness for a few seconds, and falling. Her dizzy spells increased. She became so weak she had to be aided in walking. Had to remain in bed at all times for nineteen months previous to admission. Would have spells of crying without apparent cause. Repeated she was going to die. Was rather childish and seemed very forgetful. Would repeat questions and stop in the middle of a sentence and start talking about something else. Unable to see to read. For three weeks before admission, seemed to remember better and was able to sit up in a chair.

Examination showed shaky speech, ataxic gait, parkinsonian tremor of right upper extremity, rigidity of muscles of left elbow, pupils pin-point-equal regular, inactive to light and accommodation, lateral nystagmus—eyeballs prominent. Abdominal reflexes absent bilaterally. Knee jerks sluggish on left, active on right. Biceps, triceps, wrist reflexes active, both sides. Babinski present bilaterally. Oppenheim present both sides. Hand grip poor. Muscular co-ordination poor. Hearing and vision impaired. Diminished and variable sensations of pain, heat, and cold. Involvement of 2, 3, 4, 6, and 8 cranial nerves. Ophthalmoscopic examination showed optic atrophy. Urinalysis essentially negative. Blood picture normal. Blood sugar within normal limits. Blood Wassermann negative. First spinal fluid examination showed Wassermann negative—9 cells flat colloidal gold curve and trace globulin with normal sugar. Repeated spinal fluid examination showed Wassermann negative, 4 cells, colloidal gold curve 3320000000, trace of globulin.

Mentally patient was fairly clear for the most part, somewhat irritable and constantly euphoric. She was well oriented, showed good memory for most part and was coherent and relevant. Also showed emotional lability, talked freely and frequently, showed periods of irritability.

Course of case. A differential diagnosis was considered between multiple sclerosis, paralysis agitans, and hysteria. Final diagnosis made of multiple sclerosis based on rather typical textbook picture with neurological findings. Repetition of neurological examinations did not show any change even during short period of some apparent improvement. On February 17, 1931, patient died.

Terminal condition started two days previously with elevation of temperature to 105. There was dysphagea cyanosis of right side of body. Pupils dilated, active to light and accommodation. No other change in neurological findings. No post mortem obtained.

Prognosis. There is very little tendency toward recovery, although Charcot and Marie have emphasized the possibility of the disease becoming arrested.

Treatment. In view of a theory which expresses the belief of a spirochete being the responsible agent, the treatment of this condition with mercury and neoarsphenamin has been tried by various observers with more or less beneficial results. However, there are no specific remedies known. Iodides have been tried; colloidal silver preparations recommended, either by inunction or intravenous; sodium nucleinate has also been advised. Physical exertion should be avoided. Extremes of temperature are harmful. Veronal and hyoscin are advised for the tremor. In the acute attacks, eliminative treatment helps. For marked weakness of legs, passive movements, massage and mild exercise frequently lead to definite improvement. For the spasticity, passive motion warm baths and baking

have proved beneficial. Methods of re-education are helpful. For the past two years physical therapy has been undertaken and used extensively with apparently good results noted. Very recently sodium amytol has been recommended.

THE SCOPE OF CLINICAL PSYCHOLOGY

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Clinical psychology is not a branch of medicine; and the clinical psychologist, not being medically trained, does not attempt or pretend to practice medicine. Rather clinical psychology and medicine are co-ordinate professions, each of which may and should be of much use to the other.

Psychology is very grateful for the aid which medicine is continually giving it. Unfortunately, many physicians seem unaware that the psychologists have anything to give them in return. It is common, though by no means universally so, for physicians to scoff at psychology and say that they do not need any help in diagnosing cases of mental deficiency. Often this is quite true. But it is also true that many of these cases which can be diagnosed without psychological examination can be diagnosed by the layman as readily as by the physician. It takes no specific training to decide that a low-grade idiot is mentally defective. But with the higher grade deficiency cases the problem is more complicated. It is with these cases that the use of the psychological test becomes more apparent. The physician without psychological training runs grave danger of mistaken diagnosis in cases of low, normal, or high-grade deficient intelligence. The psychologist, making use of various intelligence tests, can be of great use to the physician in diagnosing these doubtful cases.

In the practice of psychology, the examination which results in mere diagnosis and nothing else is of little practical use. To be of value, diagnosis must inevitably lead to prognosis and prescription of treatment. Witmer has been quoted as saying that every psychological diagnosis is also a prognosis. It is true that, in most cases, by use of intelligence tests, the psychologist can predict, with a fair degree of certainty, the probable mental development which the child being studied will have attained on maturity.

This prognostic value of intelligence tests makes them of great use in the fields of vocational and educational guidance. One of the main duties of the clinical psychologist is his endeavor to prevent round pegs from trying to force themselves into square holes. It is important that no child be allowed to aspire to a career which is not suitable to his intellectual level. This is applicable to all degrees of intelligence. It is just as disastrous for the individual to attempt work which requires intelligence markedly lower than that which he possesses as it is for him to attempt work requiring intelligence superior to his.

Educational guidance is, of course, very closely related to vocational guidance. The practice of many vocations requires specialized educational training. It is important that the child's vocation be decided at an early age so that he may receive the prerequisite educational training.

Aside from assisting in pre-vocational guidance, the psychologist can make various other contributions to the educationalist. No child should be placed in an orthogenic backward class until after he has been examined psychologically. Moreover, grade-placement should, to a certain degree, depend on the psychologist's recommendations. Many behavior difficulties and other maladjustments result from improper grade placement. No child can be expected to do satisfactory work in a grade which requires greater mental development than he possesses. At the other extreme is the child who misbehaves because he finds his school work too easy and consequently boring.

The child of normal intelligence who has a specialized educational defect should undoubtedly receive psychological examination and treatment. For example, many cases of reading disability have been greatly improved following special training based on psychological recommendations. The child with a special ability, be it artistic, literary, musical or mechanical, should be examined psychologically so that his talent may be evaluated and special training initiated.

Most of the type of cases mentioned so far are apt to be referred to the psychologist by the school rather than by the physician. Neverthe-

less, every general practitioner occasionally has a case which falls into one or another of the forementioned categories. In such cases, he will surely find a psychological examination worth while.

The physician and psychologist should co-operate closely in the examination and treatment of cases of speech defect. If the defect is on an organic basis the psychologist can do little in the way of treatment until after the necessary medical or surgical treatment has been given. After this, however, the work of the psychologist may be of value. It has been found that many children with speech defects due to cleft palate do not learn to speak correctly after the palate has been repaired unless they receive special training. It is with this training that the psychologist is able to assist. In cases of functional speech defect the problem of speech correction is entirely psychological rather than medical.

No child should be committed to an institution for the mentally defective until after he has been examined psychologically. Although, such an occurrence is rare, it has at times happened that a child has been considered defective when his defect was apparent rather than real. The only way to be sure that no non-defective child is committed as defective is to have every child examined psychologically before commitment.

Although most of the cases referred to the psychologist are children, in occasional cases it is desirable that an adult be given a psychological examination. Since it has been found that a large proportion of criminals are mentally defective, it is not surprising that psychologists are frequently called upon to examine prisoners before they are tried. Of course, such examinations are always given in connection with psychiatric examinations. Also, almost invariably the psychiatrist and psychologist co-operate in the study of the child who presents a behavior problem or has become delinquent.

It is evident that the scope of clinical psychology is very broad, the psychologist being interested in educational guidance, vocational guidance, intelligence testing, speech correction, study of the delinquent, the criminal and the behavior problem. Psychologists feel that they can do much constructive work in each of these fields; but they also feel that this work will be of little value unless it is done in co-operation with physicians.

TESTS USED IN THE MENTAL HYGIENE CLINIC AND WHAT THEY MEASURE

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To those unfamiliar with testing technique and theory the procedure followed in the Mental Hygiene Clinic can be best demonstrated by the citation of a typical case and an explanation of why certain tests were chosen as applicable to this case. The following example will illustrate the types of tests most frequently used, the reason for using these tests and the information concerning the individual case that the tests can give to the psychologist.

THE CASE OF JOHN

John is in the eighth grade and will just manage to achieve promotion at the end of the year. He is sixteen years old and large for his age. A series of accidents and illnesses has caused him to lose much time from school and is partially responsible for his retardation. He is referred to the clinic by the school principal for educational and vocational advice from the clinic. The question of the advisability of his entering high school has arisen. His parents are anxious for him to continue his education and the principal believes the boy has ability that should be further developed. His teachers complain of lack of interest, except in mathematics and manual training, and think he will be unable to carry high school work successfully. John himself is opposed to the thought of high school. He is looking forward to the end of the term and to a job promised him by the druggist. He will serve at the soda fountain and act as general clerk, and his salary of ten dollars a week seems entirely satisfactory to the untrained, inexperienced boy, particularly in a time of general economic depression. He admits lack of interest and effort in school work, and is positive that he does not want to go to high school. With this information at hand the psychologist begins to administer certain tests.

I. THE STANFORD-BINET TEST

First of all, John is a new case. He will therefore be given the intelligence test used routinely for all new cases except infants, that are seen by the psychologist. This test is the Stanford Revision of the Binet-Simon Scale, commonly

known as the Stanford-Binet Test. It is the the most widely used and recognized individual test of general intelligence. This scale consists of ninety standardized tests arranged in order of difficulty, from some that should be passed by a child of three years to others that demand what is known as "superior adult ability." The individual responds orally to the questions asked by the examiner and his responses are compared to the standardized answers. Each completed correct response is considered equivalent to a certain number of months and the total number of months earned constitutes a measure of ability known as "mental age." The mental age is then compared to the individual's chronological age and this ratio is known as the intelligence quotient or "I-Q." Success in this scale of tests is closely correlated with scholastic success.

Let us now see why this test was routinely given to John, who represents a new case.

From his responses as a whole we find that his "general intelligence" is average. He earns a mental age of one hundred and ninety-two months or sixteen years, corresponding exactly to his chronological age, and giving him the ideally average intelligence quotient of one hundred. The test further tells us how this average ability is distributed. Some of the questions are designed to measure reasoning ability and on these he did well. Others measure judgment and on these he is fairly good. His memory is poor, but he has ability above the average in visualizing or "seeing in his mind." We have now learned that, despite his poor school grades, John is capable of fairly good school progress—much better than he is now making. He should be doing second year high school work now. This much the Stanford-Binet Test can tell us. But this is not enough. Why is his progress so poor? Are his teachers correct in their belief that John will fail in high school?

II. EDUCATIONAL ACHIEVEMENT TESTS—THE STANFORD ACHIEVEMENT TEST

To determine such questions a test must be given which measures scholastic achievement in the usual grammar grade subjects, or what a pupil has actually learned in school as distinct from his degree of general intelligence. It is well known that a bright child does not always make the most of his ability, while a dull child, by faithful effort and persistence, may achieve more than his actual ability alone might warrant. We must find how John stands in relation to achievement in various subjects. For this purpose the Mental Hygiene Clinic uses the Stanford Achievement Test, which has been designed for use with groups of grade-school children, but which may be administered as an individual test. Separate tests, with various time limits, are given for reading comprehension (including tests of word-meaning, sentence-meaning, and paragraph meaning), arithmetic computation, arithmetic reasoning, history and literature, nature study and science, language usage, and spelling. The scores are converted by means of a table into separate achievement ages for each subject and the sum of all the scores is converted into the total educational age. The ratio of educational age to chronological age gives the educational quotient.

By means of this series of tests which measures accomplishment in separate subjects, and also accomplishment as a whole, we learn several facts concerning John. First of all, John's achievement in school work is less than it should be for his level of intelligence. The test result shows an educational age of fourteen years six months, which is a year and a half below the level of his mental age. That means that tho his intelligence is sufficient to enable him to grasp what the average sixteen-year-old boy in second year of high school grasps, his foundation in the elementary school subjects is comparable to that of a fourteen-year-old, just finishing the eighth grade. If he now enters academic high school, the chances are that he will fail first-year English. His vocabulary and knowledge of word meaning, and his knowledge of the correct use of the English language correspond to that of a child of twelve and one-half years, which is insufficient preparation for academic high school work. He will have some trouble with history, but will probably achieve high scores in high school mathematics, as his achievement in arithmetic reasoning and computation is at the level of his mental age—sixteen years. His achievement in science and nature study is that of a fifteen-year-old, which should be adequate for beginning high school general science. But the boy himself is antagonistic to the idea of high school, and a failure in English will further increase his an-

tagonism. The achievement tests show that with interest and effort he might maintain satisfactory averages in all but one subject during his first year. With hard, concentrated effort and his degree of intelligence, he might even succeed with English. In the face of his attitude towards high school, his weak foundation in English, and marked lack of interest in academic work, failure can almost certainly be predicted, not only in English, but in other subjects. His intelligence is sufficiently good, however, to warrant some further educational training.

At this point it is discovered that John is interested in mechanics. The prospect of an immediate "job," together with his antagonism towards the idea of high school, have temporarily overshadowed this interest; but when questioned, he speaks enthusiastically of tinkering with old cars, and with a radio. He has never thought of training along such lines, and the possibilities of trade school seem not to have been considered, but he now decides that he would like to enter the trade school. Before recommending that he do so, the psychologist should have some idea of his mechanical ability other than statements of his interest in mechanics.

III. The Stenquist Test for Mechanical Aptitude

The Stenquist test is widely used with adolescent boys as a test that is symptomatic of mechanical aptitude. The test consists of two parts: the assembly test, and the paper test. In the assembly test the boy is shown a series of mechanical objects already taken apart—bicycle bell, paper clip, lock, mouse trap, etc., and is told to assemble these as rapidly and correctly as possible. His performance is compared to the norms for boys of his age, to the norms for older boys, and to the norms for adult men. This test has been found indicative of mechanical aptitude, though all mechanical capacities are not tested.

Applying the assembly test to John, it is found that his performance earns a score that is equalled or exceeded by only 7% of adult men —a high score which indicates that training along mechanical lines will be highly profitable.

Conclusions in the Case of John

A summary of the psychologist's findings in John's case shows:

1. Good average intelligence, with good reasoning, fair judgment, poor memory and good visualization ability—(as measured by the Stanford-Binet Test of General Intelligence).
2. Good arithmetical achievement, good reading comprehension, poor knowledge of words, poor progress in the correct usage of English, and fairly good achievement in elementary science—(as measured by the Stanford Educational Achievement Test).
3. Very good mechanical ability—(as measured by the Stenquist Test of Mechanical Aptitude).

The recommendation is made that he enter the trade school. Training for a definite occupation is far better than immediate earnings in a more or less "blind alley job" that offers little promise of advancement. His education should be continued, and his native ability developed as far as possible. Hence further schooling is advised rather than immediate employment. He seems mechanically inclined, both as to interest and ability, and his knowledge of arithmetic, his good reasoning ability, and good powers of visualization are ready assets towards success in trade school. On the other hand, his poor achievement in English will be much less of a handicap in trade school courses than in academic high school courses, and his chances of success are greater than in high school courses in English which tend to emphasize fluency of expression, both oral and written. John is content with the plan for his future and his parents agree to the trade school proposal.

All three types of test were necessary before conclusions could be reached, for each test represented a distinct and different measurement. A different combination of tests might have been chosen for a different type of case. Few cases referred to the Mental Hygiene Clinic can be completed with the use of but one test.

Tests are many, and the ones chosen for use vary somewhat in different clinics. There will always be, however, tests of:

1. General Intelligence.
2. School Achievement.
3. Special Aptitude and Abilities.

There will always be different forms of each

of these types of tests that are suitable for different cases. Infants of two years will neither receive the same verbal intelligence test nor the same scale of performance test for manual ability that the child of ten years will receive. Achievement tests for a second-grade child are not suitable for an eighth-grade pupil. The Stenquist Mechanical Aptitude Test would be useless in determining the cause of reading disability.

John's case was chosen because it portrays the type of case in which tests and their results are prime factors in the disposition of the case. There is no particular social or psychiatric problem here—the problem is simply one of educational and vocational advice, given largely on the basis of tests made. John is interviewed by the psychiatrist, and a social history gives necessary information concerning the boy and his background, but there is no question of a behavior difficulty or a social maladjustment. The boy's somewhat defiant attitude is quickly dispelled when the trade school plan is discussed, and the recommendations based on the test findings meet with the approval of the school and of his family.

The cases seen in the Mental Hygiene Clinic often present more complex problems and may require more or less intensive psychiatric treatment and social adjustment. Testing, however, will always be an important factor in the treatment and understanding of the case, because the child's general intelligence, special abilities and disabilities, and school achievement as measured by standardized tests and interpreted by the psychologist, will present to the psychiatrist a component without which his understanding of the individual child would be incomplete.

PSYCHIATRIC SOCIAL WORK AS A FACTOR IN A MENTAL HYGIENE CLINIC

AUDREY D. DENISTON
Farnhurst, Del.

Psychiatric social work, as such, has been in existence since the World War period. Its aim is to contribute to the improvement of the individual's mental health and to assist him to make a better social adjustment. The scope covers a wide range of activities and a long list of items that are difficult to circumscribe, yet there is a starting point and a control; namely, the psychiatrist's study of the individual who shows some deviation from mental health standards, whether it be found in a so-called problem child or in an adult with symptoms of an incipient mental illness. The work involves investigation, analysis or interpretation, and treatment; the technique for procedure is based upon and follows general social case work principles.

No attempt is being made to set forth any complicated details of organization, but merely to place psychiatric social work as an integral part of a clinic consisting of a psychiatrist, a psychologist and a social worker.

It might be well before presenting a concrete situation to give some idea of the equipment necessary in a psychiatric social worker's background. Formal training includes an appreciation of the medical and psychiatric aspects involved in social adjustments as well as some knowledge of political science, psychology and sociology. A worker should know the resources and social structure of the community in which the clinic is located. To be more specific, there should be a knowledge of the customs and background of the people; also, information about the schools, churches, hospitals, recreational facilities, children's and family societies, public health nursing organizations, visiting teachers and court workers, as well as something of the laws and the methods of their enforcement.

The fundamental task of the social worker is the discovery of motives that lie behind each problem of maladjustment which is being studied. It is evident then, that the first step toward this goal is the gathering of material indicating the forces which have operated to influence the individual's development. These data are compiled in a psychiatric social history which includes family background, personal history and environmental influences. Pertinent facts may be found in disease entities and physical surroundings, but it is also important to evaluate the attitudes and family relationships of the group in which the individual has lived. In the actual performance of this task of securing information, the worker acts as an interpreter both to the clinic and the community. She brings to the examining staff a picture of the person in his environment in addition to that

presented by the individual in the clinic. She in turn projects the clinic into the community by explaining to families and interested agencies its general function as well as interpreting the more specific recommendations formulated by the staff after a complete examination.

Take a concrete illustration, the case of the little Italian boy who was referred to a clinic because of his truancy and stealing, and although eight years of age, he was still in the first grade in school. He had been expelled from the parochial school because of these difficulties and had subsequently entered the public school; however, the only time the mother was sure of his attendance was when she accompanied him to the building and delivered him into the hands of the teacher. He had stolen money from his father's pockets and from nearby newsstands as well as candy and cigarettes from the corner drug store.

In presence of the unfamiliar surroundings of the clinic, the boy appeared somewhat like a frightened animal and gave little spontaneous information to the psychiatrist. Physical examination revealed no defects and he appeared to be in good physical health. The psychological examination could not be completed during the first visit to the clinic, but there were results sufficient to warrant the decision of his having at least average native intelligence.

The following information secured by the social worker added to the above incomplete picture: the family, consisting of the parents and six children, occupied two rooms in the rear of the father's barber shop. There were present only the bare necessities in furniture. The children were meagerly clothed; they had only a few toys and because the father's business had declined, the mother usually did not have more than four dollars a week with which to buy food. Due to the fact that their nationality was different from the other residents of the immediate neighborhood, the family had not been accepted socially. The other children had caused no trouble; however, two were under school age, one in kindergarten, and another in first grade. An older child, also a boy, had found congenial companions in an adjoining locality, but patient was not included in his play group. The fact that patient was the only one causing difficulty, justified the father in his own estimation for whipping him repeatedly and severely, with the result that the child stayed out late at night, often taking with him the back-door key in order that he might slip in after the family had gone to bed.

In obtaining the history, of which only a short summary is given, both parents were interviewed. Through a central bureau which registers social agency contacts, it was learned that the family had never applied for relief, though they would have been justified in doing so. This fact is significant in interpreting the parents' attitude in their struggle to maintain economic independence. A legal aid society had acted in behalf of the father when he was sued by his landlord for back rent, and a health station had advised the mother about feeding the youngest child upon request of a visiting nurse. It should be added that this nurse was instrumental in referring the child to clinic for study. The teachers where he had attended school gave a history of petty stealing over approximately a year. No one had been successful in interesting him in school work or in establishing any study habits. The attendance officer had known him only since his attendance in public school, but in this short time she had tried to impress the father with the idea that his methods of punishment were undesirable in an effort to correct patient's truancy and stealing habits. A neighbor who had become interested in the children confirmed the impression of the family's isolation socially. The druggist from whom patient had stolen candy and cigarettes added to the store of information, having seen him begging on the streets and slipping apparently unnoticed into picture shows during school hours. A friendly relationship was established with patient by calls in the home and by his return visits to the clinic before it was learned that he had become identified with a gang of older boys who gave him small sums of money for stolen goods.

Because of the lack of resources in the home, the psychiatrist recommended placement elsewhere in an effort to establish some regular school habits and to break the influence of the gang. Detailed steps in the success and failure of treatment need not be recorded, but since the child could be considered neither a dependent nor a delinquent, it was difficult to find a suitable place for him. Finally, an institution, in

the nature of a parental school was the only alternative. There, however, he made a satisfactory adjustment over a period of three months and in the meantime the family planned to move to another locality, before taking him back into their home.

Other examples, relating situations comparable or in contrast to the above, might be given to show the function and scope of social work in a mental hygiene clinic. The same procedure, however, would be followed as a general working basis. There would be present the same control, as the tasks involved in the work begin with the clinic's study of the individual's deviation in personality, and are extended upon recommendation of the clinic staff into the field of treatment which involves both the individual and the environment.

IMPORTANCE OF SOCIAL HISTORIES IN MENTAL HOSPITALS

ZILPHA GUILFOIL
Farnhurst, Del.

As each patient admitted to the hospital must be studied individually, it is important that a comprehensive social history must be compiled and filed with the other records in each case.

This history must include, as completely as possible, the personal history of each patient and must be so thorough as to give the examiner a clear-cut picture of his or her life from birth to the time of entry to the hospital.

As emotional trends and personality patterns are developed very early in life no significant details of childhood must be overlooked. Especial emphasis must be made regarding the health of the mother during pregnancy, the nature of delivery, birth injuries and the nutritional condition of the child, following this with minute detail as to the mode of feeding the infant, habit-training, progress of the infant's development, and the care and training during the pre-school age.

As the picture evolves, the school records must be examined to learn the mental status, discover behavior difficulties and perceive personality trends, carefully describing these so that a clear-cut view may be obtained of how the patient adapted himself in these formative years. Later, adolescence must be fully considered and care must be taken to discover any marked personality or behavior change at this time.

It is important, too, to learn the precise grade attained in school and whether or not the patient's ambitions were fully satisfied along this line and if not, how much of an effort was made by him to obtain further education, independently of other help.

The sexual life of each patient must be scrutinized carefully, for sexual adjustment or maladjustment is significant in some types of mental disorder.

If married, the family relationships of the patient are equally important. Difficult situations in this relationship are often zealously guarded and much care and tact must be used to bring to light the real situation. Included in this problem, is the determination of the attitude of the children of the patient toward him or of other members of the family living in the home.

The health of each patient must be studied and information obtained regarding any serious illness or injury from professional sources.

The employment record of each individual must be examined to determine if the patient was adjusted to his work and had progressed satisfactorily. Often, the first symptoms of mental trouble is shown only by instability at work.

Then the career, goal and "drive" of each patient must be described and studied to provide the examiner a guide to discover the real aims and aspirations, or mental conflicts of each patient, or mental conflicts.

In addition to this vital personal history, facts must be obtained about the environmental cultural and recreational background of each patient, as conditions discovered along these lines may account for some of the symptoms of mental trouble and often have a direct bearing on the decision as to when and how it is best to parole patients.

As each state hospital must keep statistical records, it is also necessary to obtain an accurate family record for four generations, concerning race, birthplace and longevity, and causes of deaths.

Many patients find their way to state hospitals who may be ineligible for treatment because of their citizenship status. It is, therefore, extremely important to obtain the correct length of time each patient has been in the state, or

whether or not those of foreign birth are aliens and can be deported. With proper historical data, deportation of such patients can be arranged with other states or, in case of the aliens, with the Immigration Commission of the government. Also, many others can be transferred to the care of the United States Veterans' Hospitals or to the United States Public Health Hospitals, thus relieving the state hospitals of the expense of maintaining such patients.

The historian must use discretion in procuring all these data. The work is extremely confidential and no unnecessary calls or inquiries should be made.

The family's pride and the wish for no publicity must be respected. But when properly introduced and the need for information is carefully explained, the utmost co-operation of all the interested parties is invariably obtained.

COMMUNITY PARTICIPATION IN A COMMUNITY CLINIC

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Mental hygiene is for every person in a community. Even the so-called normal individuals can benefit from the practice of its principles. None of us ever achieve a perfect degree of social adjustment. On the contrary, there are so many grades that it is hard to tell where "normal behavior" leaves off and mental aberration begins. Mental hygiene is particularly applicable to present needs. In this period of social transformation, all are faced with the obligation of adapting themselves to new and changing conditions of society and mental hygiene points a way.

Social progress in a community depends on the social consciousness of that community. The effective organization and functioning of its social forces are, in a measure, the responsibility of all. Public and private agencies are the instruments for service, but after all, the success of any movement in a community depends on the interest of its members and their willingness to participate in it.

Mental hygiene is one of the new social forces in community life. One part of it is concerned with the provision of facilities for the recognition, care and treatment of the mentally ill and defective, but of wider interest in the community is the primary phase, carried on largely through guidance centers and community clinics for the purpose of preventing nervous and mental disease and promoting good mental health. Prevention starts with the child and his problems so naturally, the popular conception of clinic service is that of child guidance. In practice, however, all mental hygiene clinics handle a variety of problems concerning both children and adults. It is common knowledge that child guidance usually expands into adult guidance. Behavior difficulties and personality disorders result from a lack of adjustment in the home, the school or society. It is only logical then to expect that the broad social implications of these problems will reach back into the community in the course of examination and treatment.

The modern method of studying individual maladjustments is by the psychiatric approach. All the techniques developed in the field of medicine, psychiatry, psychology and social work are used in psychiatric practice. In the search for underlying causes of human behavior, it is impossible to separate the physical, mental and spiritual makeup of personalities. Studying individuals from this point of view results in greater respect for personality, and deeper understanding of facts of life. An individual is seen as he really is and not as he should be. One phase of his difficulties is not considered without due regard for all factors or combinations of factors which may contribute to the problem as a whole. We know that poor hygiene, faulty emotional adjustment, and economic and social insecurity all tend to create behavior problems and sick personalities.

A false start is made if investigation and examination are not thorough and complete. A cross-section study of a personality is not sufficient. Life history is essential to provide a complete picture. More trouble and confusion may be added to the problem already presented for lack of exact knowledge. Family and community attitudes have such an important bearing that it is folly to plunge into a study without first determining where everybody stands. The success or failure of study and treatment often depends on this. If clinic service is unwelcome, it is sometimes worse to focus attention on an individual or his family and do nothing further

than had the problem gone unnoticed. The same can be said about creating the impression through investigation of having done something about a situation and letting the matter rest there. Inquiry into other people's problems is only warranted when investigation is followed by constructive treatment.

Successful procedure rests largely on co-operation, and on a scientific attitude on the part of those associated in the work. In studies where human relations are involved, it must always be remembered that we are dealing with dynamic situations. The same comprehensive and objective method practiced with the patient and his family must also be applied by the practitioners and agencies in their relations, one to another. Narrow loyalties and jealous competition must be scrapped for harmonious co-operation. An open mind and a desire to understand are the indispensable instruments of all who are engaged in the social services.

It must be understood that mental hygiene is not the job of any one group in a community. A clinic serves as an agent for applied mental hygiene, but it cannot function independently nor in a wholesale way. It not only relies on parents, schools, social and health agencies to refer persons for study, but in turn refers back to them for help in administering treatment. Maladjusted individuals drawn from the community must be readjusted through community resources.

The community clinic is a center for the demonstration of mental hygiene. It has boundless opportunity to prevent mental and social ills, and to improve mental health; but these goals can only be made with the participation and good-will of the entire community.

Social Insurance Is Contrary to the Fundamental Principles of Democratic Government

E. H. OCHSNER
Chicago, Ill.

All forms of social insurance are contrary to the spirit of democratic government. They destroy individual incentive, initiative and self-reliance. They substitute paternalistic control for independence of thought and action. We pride and congratulate ourselves on living under a democratic form of government, but most of us fail to realize that we are slowly but surely drifting away from the true democratic spirit in government—that we are gradually substituting a hybrid form of government, a cross between bureaucracy and socialism. Personally, I am a firm believer in democracy and believe that many of our present ills are the direct result of already having deviated too far from the fundamental principles of democracy.

Individual responsibility is the foundation of democratic government. If a nation does not educate its citizens to individual responsibility, it will soon have no one capable of assuming public responsibility. Slowly through the ages the common man has risen from chattel slavery and serfdom to independence, freedom and personal liberty, and now some well-meaning but misguided people want to undo all this. They want to enslave him again, making him in fact a bondsman of the state. Organized society is forever forging new chains with which to shackle the free development of its members. It is forever meddling with the private affairs of its citizens. One of the best illustrations of this statement is found in a recent survey of the Citizens' Bureau of Milwaukee which found that that city is engaged in approximately three hundred different functions, one-fifth of which have been added during the last sixteen years. Milwaukee is no worse in this respect than many other cities in this country. Add to this the activities of the county, state and Federal governments, and we find an explanation of the following fact—"In a period in which the population of the United States has increased ten per cent the number of persons holding civil office has increased forty per cent and the amount paid in salaries has increased one hundred and fifty per cent. Thirty years ago one person in every forty-five was in government employ while now one in every twelve is so employed.

"It is a profound mystery why the people of the present generation should so violently run after the very things their forefathers so violently ran away from in 1776. One of the chief indictments of King George set forth in the Declaration of Independence reads: 'He has erected a multitude of new offices and sent hither swarms of officers to harass our people and eat out their substance.' "

In a recent article, Dr. Harry Emerson Fosdick makes a statement that seems particularly suitable in this connection. He said, "Many of those in society who are dissatisfied with present conditions know what they want to get away from, but they do not know whither they are going." I would add "nor do they seem to have any clear idea as to what they want." Before we adopt new laws we should make reasonably sure that such laws will not introduce new and greater evils than they are expected to cure, that they can actually be enforced, and that they are not likely to be abused in their administration.

A far-reaching innovation such as social insurance must be viewed from many angles. We must consider its effect upon the general public, the insured, the employer, and the medical and dental professions.

If we are deliberately trying to get away from the democratic form of government having a definite objective in view; and if we are reasonably certain that the goal for which we are headed is worth while and is going to result in general social and economic betterment, an experiment with social insurance might be justified, but, even then, it is well to carefully weigh and consider what the wise founders of our government had to say on this important subject. I quote from the Declaration of Independence "Prudence, indeed, would dictate that government long established should not be changed for light and transient reasons." If we as a nation are just aimlessly drifting, as we seem to be, we are almost sure to get into serious trouble. We believe that we shall be able to show conclusively, in future articles, that in those countries in which it has had prolonged and extensive trial it actually has had serious consequences. These latter problems will be taken up in subsequent articles.

EDITORIAL

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The increasing interest of society in the mental health of its individuals is a movement for which there has been a long need, but which has been neglected during the past. Although the world has long realized that the inadequate, the criminal, and the deficient were an expensive burden to those who successfully carried on their daily life, yet these human liabilities were supported through taxation and donations of the rest. Consequently, the reliable citizen does not only support his own family, but helps in the support of hundreds of thousands of others. Any movement which will relieve this burden will necessarily be an economic relief.

Aside from any financial gain the human viewpoint must be taken into account. Any method which will adjust the maladjusted, and make of him a happy useful citizen is worthy of our careful consideration.

But the greatest benefit which the recent interest in mental aberrations can bring to the world at large is the discovery of the etiology of these conditions. Since every result has its cause, it is the duty of the leaders in this field to find the cause of maladjustment. As no condition can be remedied until the etiology is discovered, so harmonious, useful lives can not be produced until the causative factors of poor adjustment are found and removed.

Perusal of the literature gives us many theories and a few facts and there is a crying need for more facts and fewer theories. Since the medical profession has taken over the field of mental deviation, this should be a challenge to them to study further until more concrete knowledge is obtained. The theologian and the physician are the two people who have access to inner thoughts of the individual. The physician, with his understanding of the correlation between the body and mind, is the one who can attack this problem with a scientific attitude, trained, as he is, to take all factors in account. Let us hope that the medical profession does not leave all in the hands of the specialist, but that he sees his patient not only as a physiological being, but as a psychological one as well.

EDITORIAL NOTES

DEAR DOCTOR:

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We want THE JOURNAL to serve *you*.

Another "Volume I, Number I," and a very good one. This time it is the Medical Annals of the District of Columbia. The format is pleasing, and conforms to the other state journals. The text is well written by members of the Medical School faculty (Georgetown University), and the editorial department is well handled. The first issue contains 24 pages of

text and 18 pages of advertisements, a most auspicious beginning. THE JOURNAL extends its sincerest greetings to the newcomer, and wishes it every possible success.

The December examination, in Materia Medica, of our State Board, contained the following question:

> Give official names of the recognized pharmacal equivalents of the following:
> (a) Phenacetin, (b) Veronal, (c) Atophan, (d) Duotal, (e) Urotropin, (f) Tolysin, (g) Luminol, (h) Trional, (i) Sulphonal, (j) Diuretin.

None of these drugs, under these names, is official, and none was taught, as such, in any class A medical school. The names, in fact, are proprietary trade-names, badges of commercialism, some of which have even been trade-marked or patented! No self-respecting medical school would lower its dignity enough to teach such patented nicknames, though the student may be very apt in picking them up untaught. Such a question has absolutely no place in a State Board examination; the papers in this subject should be regraded.

Pay your dues, *now!* The importance of always being in good standing in your county and state society is not aways appreciated. But in these days of hard times, with a certain element constantly looking for easy money from the doctor via a damage suit, it pays to pay attention to your medical society, so that it, in your hour of trouble, will be able to pay attention to you. So, PAY YOUR DUES NOW!

HOME TOWN HOSPITALS

A newspaper clipping from the *Parkersburg Sentinel* has recently been received from a prominent West Virginia doctor. He wrote, "This clipping, I feel, would be of interest to the medical profession and should be reprinted in the JOURNAL." The clipping speaks for itself, so we publish it without comment.

"Mayor Floyd S. Chapman, of Huntington, who a few weeks ago was elected to office by an overwhelming majority, recently was stricken at his desk and was taken to a Cincinnati hospital to undergo an operation. Huntington is supposed to have some of the best hospitals in the country, but the mayor of that town, like most other outstanding personages in a community, hastens to a big city hospital when he becomes scared about his physical condition. Sometimes we wonder whether those big city hospitals are really any better than the home town institutions."—*W. Va. Med. Jour.*

Read the new Code of Ethics of Industrial Surgery, on page 55, and then live up to it.

DELAWARE PHARMACEUTICAL SOCIETY

SUBSTITUTION

Again and again the old bogey, substitution, raises its head and comes stalking through the land, all too frequently casting unwarranted suspicion upon a vast army of reputable pharmacists to whom the mere thought of betraying the confidence of physician or patient would undoubtedly prove quite as obnoxious as it could possibly be to the owner of any trade-marked product. While in our opinion the percentage of pharmacists who would actually be guilty of using or dispensing substitutes for any well-known trade-marked product, whether called for on prescription or over the counter, is relatively small, the fact remains that serious charges of this nature crop up from time to time. We feel, therefore, that the matter is of sufficient importance to warrant brief reference in these columns, with a view to shedding some light on the subject and more specifically to direct attention to the evil consequences that departure from the path of rectitude in the dispensing of trade-marked articles is sure to bring about.

Complaints of this nature are quite numerous just now and it is a source of deep regret to learn that more than one manufacturer of trade-marked products has found it necessary to employ a corps of detectives or field men to go about through the country making purchases and having prescriptions filled in order to test the honor and integrity of retail druggists when trade-marked articles are called for.

Although there is nothing we can add to the statements previously made in these columns regarding the illegality and injustice of substituting one product for another without the knowledge or consent of physician or layman, as the case may be, it may not be amiss to repeat the

assertion that retail druggists are under both legal and moral obligation to dispense nothing but the trade-marked article when such a product is prescribed under a distinguishing name by which it is known to the trade. In other words, no substitute of any sort should be used or dispensed when products such as luminal, argyrol, listerine, etc., are specifically designated. This well-known rule of law as well as correct business conduct holds good in every instance, regardless of the dispenser's personal views as to the chemical or therapeutic qualities of like products.

In setting forth these facts we wish also to make it perfectly clear that the dealer in drugs unquestionably has the right to make his own antiseptic solution and sell it as such just as often as he chooses and the opportunity arises to make such sales, provided only and always that the article is sold on its own merits and under its own name. Obviously, this common sense rule of business practice applies with equal force to any and all preparations which retail druggists may be called upon to make, even though there be a thousand and one trade-marked articles of similar nature, but in no case should liquor antisepticus, for instance, be dispensed for listerine, or silver nucleinate for argyrol, or phenobarbital for luminal, because the products thus designated are protected by the law which gives the trade-marked owner the exclusive use and control of such trade names and, of course, these rights should and must be respected.

We regret the necessity of again referring to this very distasteful subject, but we do so in the hope that if there be an isolated case here and there in which the retailer still labors under the impression that products of a like nature, from a chemical or pharmaceutical standpoint, are interchangeable, regardless of trade-mark or other proprietary rights, all such erroneous impressions may be quickly dispelled and the cause of complaint eliminated without further ado.

We are unwilling to believe that wanton substitution is practiced to any appreciable extent by the druggists of the country, but so much is at stake when charges of this nature are hurled at one occupying such a responsible position as pharmacist to the community, that too much care can not be exercised in avoiding even the appearance of evil.

We know the retail druggists of the country may be depended upon to do the right, just and honorable thing when the facts are laid bare.—*N. A. R. D. Journal.*

WOMAN'S AUXILIARY

The February meeting of the Delaware Auxiliary was held at the Wayside Inn, Smyrna, and consisted of a luncheon and a business meeting. The various committees reported progress. An amendment to the By-Laws was proposed, to the effect that the Auxiliary shall elect three vice-presidents instead of two. This proposal will be acted upon at the next meeting. Each member paid their dues in 1931. A delegate to the National Convention at New Orleans, in May, will be selected later. Arrangements are to be made to hear well-known authorities on health subjects at some of the future meetings. An oyster party for the men is also being planned.

Reference is made once more to *Hygeia*, the health magazine published by the A. M. A. Members of the Auxiliary are urged to interest all their contacts, especially mothers, in this valuable and informative magazine, which is published especially for the laity. If subscriptions are sent in via the Auxiliary this organization will receive a small commission, to be used in furthering Auxiliary projects.

MISCELLANEOUS

Ethics of Industrial Surgery

"Ethics in Industrial Surgery" is the title of a paper by Frank McCormick in *The Journal of the Michigan State Medical Society* for December, 1930. This article stresses the fact that the physician must safeguard the interests of his patient and preserve his own self-respect by a fine regard for the feelings of brother practitioners. At times this demands marked unselfishness and almost self-effacement on the part of the conscientious physician. The human conscience remains the best guide for man's ethics, but that conscience must be made intelligent so as to adjust itself to present-day needs in medicine. Industrial surgery is an infant specialty and there is no branch in medicine so prone to commercialization. The author says that it is

unfortunate and deplorable that professional men should be pitted against one another in a mad struggle for industrial surgery, for it causes a lowering of fees as it also lowers the self-respect and dignity of the physician, and eventually lowers the standard of work done by the industrial surgeon. However, it is a condition brought about by employers and in particular by liability insurance companies. Ethics, to be worth while, must be adhered to, and are just as essential in industrial as in any other type of surgery. To meet the need of the rules of conduct in this respect, the Wayne County (Detroit) Medical Society has drawn up a code of ethics for industrial surgeons, to which it is asked that all physicians doing industrial surgery shall subscribe. The code is as follows:

1. The Industrial Surgeon should consider his relations with the factory which he serves in the same manner as a physician called to attend a family in general practice.
2. He should in no way solicit business from or advertise himself to any industrial plant unless he positively knows that the plant in question is not being cared for by any other surgeon.
3. He should refuse appointment as surgeon by any industrial concern or insurance company concerned in the transaction until he is sure that the factory has no regular surgeon, that the surgeon has resigned, or has been discharged officially.
4. If necessary, he shall acquaint himself of the actual facts of the case by first of all calling upon the surgeon himself for a statement before entering into any negotiations whatever to take over new work.
5. He shall refuse to go in attendance to any factory regularly under the supervision of another doctor, except in emergency.
6. He shall under no conditions discuss rates or fees to any factory or insurance company, either in person or by letter, if this factory is being regularly cared for by another doctor.
7. Any compensation case following injury in a factory being treated by a physician other than the regular company's surgeon shall not be interfered with in his treatment providing he shows reasonable skill and diligence in attending the case.

   It is provided, however, that the surgeon regularly employed by the company shall be privileged at proper times and under proper conditions to consult with the attending physician to determine the progress of the case if the employer or insurance company involved so request.

   Both physicians concerned shall preserve a friendly relationship and make the welfare of the patient of paramount interest.
8. Any infringement of these rules shall be construed as an unfriendly act and shall be referred to the Ethics Committee of the Wayne County Medical Society for decision.
9. The Industrial Surgeon should in every way possible raise the standing of this branch of the profession by—
   (a) Personally supervising as much as possible the care of patients at office and factory.
   (b) Preserving a standard of fees paid by insurance companies sufficiently high to insure skillful and painstaking service.
   (c) To foster a relationship of mutual respect and trust, not only between the Industrial Surgeon and his employers but an ethical relationship with other industrial surgeons.

—*J. Ind. S. M. A.*

Oxygen Therapy Without Soda Lime

During the past two years, MILTON B. ROSENBLUTH and MORRIS BLOCK, New York (*Journal A. M. A.*, January 30, 1932), have treated seventy-five patients ill with lobar pneumonia in oxygen tents of either the Roth Barach or the McDonald type. When they first used these tents they noted occasionally that even though the soda lime was not changed for periods somewhat longer than the prescribed forty-eight hours the patients appeared quite comfortable. The soda lime was then left unchanged for periods of about six to eight days and still the patients made no complaint. Since after being in use for such long periods the soda lime could no longer be active in removing the carbon dioxide, the soda lime was omitted entirely and patients were kept in the tents in complete comfort without it. Experiments are described in which it was demonstrated that with ordinary nursing care the oxygen content of a tent cannot be maintained at a desirable level with the flow of oxygen less than 8 liters per minute. With extraordinary care to prevent leakage, the oxygen content of a tent can be made to reach over 45 per cent with 6 liters per minute, but the carbon dioxide will approach 4 per cent. With the flow of oxygen at from 8 to 10 liters per minute, the carbon dioxide will not rise above 1.5 per cent. Patients maintained in atmospheres containing between 2 and 4 per cent carbon dioxide did not experience any subjective symptoms. From their observations the authors conclude that soda lime is not necessary for the removal of carbon dioxide when large quantities of oxygen are used.